**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 09001

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Myrtle M. Shortt

2. Data of Death Month: 3 Day: 11 Year: 2001

3. Time of Death: 0445 M

4a. Facility Name *(If not institution, give street and number)*: Atlantic General Hospital

4b. City, Town, or Location of Death: Berlin MD

4c. County of Death: Worcester

**Funeral Director**

5. Social Security Number: 223-40-1546

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 67 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 6/30/1933

9. Birthplace *(State or Foreign Country)*: VA

Usual Residence of Decedent

10a. State: MD

10b. County: Worcester

10c. City, Town or Location: Berlin

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 8402 Old Ocean City RD

10f. Zip Code: 21811

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Floyd Sifford

18. Mother's Name *(First, Middle, Maiden Surname)*: Virginia (Unknown)

19a. Informant's Name/Relationship *(Type, Print)*: Charles A. James/ Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8350 Old Ocean City RD Berlin, MD 21811

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: State Line Cemetery

Date: 3/15/01

20c. Location - City or Town, State: Gumboro, DE

21. Signature of Funeral Service Licensee: Nancy A. Henderson 1100284

22. Name and Address of Facility: Burbage Funeral Home 108 William St. Berlin, MD 21811

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Liver Carcinoma

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other *(specify)* 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23a. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: William Todd MD

29c. License number: D46111

29d. Date signed *(Month, Day, Year)*: 03/12/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William Todd MD 9733 Healthway Dr. Berlin, MD 21811

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 13 2001

32. Registrar's Signature: Penny G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 09002

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Thelma Sarah Sargent
2. Date of Death (Month, Day, Year): March 12, 2001
3. Time of Death: 7:13 p.m.
4a. Facility Name (If not institution, give street and number): Waldorf Health Care
4b. City, Town, or Location of Death: Waldorf
4c. County of Death: Charles

**Funeral Director**

5. Social Security Number: 579-16-2608
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 98 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): November 23, 1902
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Charles
10c. City, Town or Location: Indian Head
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 9 Leslie Drive
10f. Zip Code: 20640
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 6
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Her Home

17. Father's Name (First, Middle, Last): Walter I. Dodson
18. Mother's Name (First, Middle, Maiden Sumama): Attie Davis

19a. Informant's Name/Relationship (Type, Print): Jean Osborne Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9 Leslie Drive, Indian Head, Maryland 20640

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Trinity Memorial Gardens
Date: March 14, 2001
20c. Location - City or Town, State: Waldorf, Maryland

21. Signature of Funeral Service Licensee: M00668
22. Name and Address of Facility: Williams Funeral Home, P.A. 4270 Hawthorne Road, Maryland, 20640

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrast, shock, or heart failure. List only one cause on each line.
Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Breast Cancer, metastatic — months
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnency 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnency 4☐ Pregnant at time of deeth 5☐ Other (specify) 9☐ Unknown
23d. Data of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23e. Did tobecco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Deeth (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2☐ Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and plece, and due to the ceuse(s) and manner stated.
29b. Signature and title of certifier
29c. License number: D0033426
29d. Date signed (Month, Day, Year): March 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): B. Larry Jenkins, MD. 111 LaGrange Ave., LaPlata, Md. 20646

**State Registrar**

31. Date filed (Month, Day, Year): MAR 14 2001
32. Registrar's Signature: Benna G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

---

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09003

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Philip J. Sheridan
2. Date of Death: Month March Day 10 Year 2001
3. Time of Death: 9:20 a.m
4a. Facility Name (If not institution, give street and number): Deers Head Center
4b. City, Town, or Location of Death: Salisbury
4c. County of Death: Wicomico

**Funeral Director**

5. Social Security Number: 212-07-8678
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 14, 1909
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Wicomico
10c. City, Town or Location: Fruitland
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 132 Liberty Way
10f. Zip Code: 21826
10g. Citizen of What Country?: U.S.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Business Owner
16b. Kind of Business/Industry: Grocery Store

17. Father's Name (First, Middle, Last): Philip L. Sheridan
18. Mother's Name (First, Middle, Maiden Surname): Ida Mae Andrews

19a. Informant's Name/Relationship (Type, Print): Celeste M. Grudzien/granddaughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4430 Smith Rd., Salisbury, MD 21801

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Salisbury Crematory
Date: 3/11/01
20c. Location - City or Town, State: Salisbury, MD

21. Signature of Funeral Service Licensee
22. Name and Address of Facility: Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Chronic aspiration pneumonia | > 10 days |
| Due to (or as a consequence of): | b. Dehydration | > 10 days |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | c. Gastroesopheal reflux disease | > 10 days |
| Due to (or as a consequence of): | d. | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Cerebrovascular disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jin J Hwang, MD
29c. License number: D16003
29d. Date signed (Month, Day, Year): 3/10/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): INJA HWANG PO Box 2018, Salisbury, MD 21802-2018

**State Registrar**

31. Date filed (Month, Day, Year): MAR 12 2001
32. Registrar's Signature: Donna B Sparks

DHMH 16 Rev 6/95

---

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0020**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Division of Vital Records, P.O. Box 68760,**

28 DQ

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09004

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|
| CHARLENE ALMA STONE | March | 8 | 2001 | 8:55 p.m. |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 4037 7th Street | North Beach | Calvert |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 578 42 2482 | 1☐ M 2☒ F | 69 Yrs. | | | Nov. 18, 1931 | USA |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Calvert | North Beach | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 4037 7th. Street | 20714 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | coordinator | Insurance |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Charles Peter Vierbuchen | Alma Rock |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| John Raymond Stone / husband | same as 10 a-f |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Fort Lincoln Cemetery | 3/13/01 | Brentwood, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Charles F. Bell, Jr. | Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Severe Chronic Obstructive Pulmonary | 4-5 years |
| Due to (or as a consequence of): | b. disease | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. Smoking in past | duration |
| Due to (or as a consequence of): | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

Congestive heart Failure

23b. **Did tobacco use contribute to the cause of death?** 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ A T Munshi M.D. Attending Physician | D 19427 | 3/9/2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ANWAR MUNSHI. M.D. Suit 303 110 Hospital Road. Prince Frederick MD 20678

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 12 2001 | ▶ Geneva G Sparks |

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09005

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Brian Scott Spencer
2. Date of Death: Month Mar, Day 8, Year 2001
3. Time of Death: 2p.m.
4a. Facility Name (If not institution, give street and number): Stella Maris
4b. City, Town, or Location of Death: Timonium
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 219-90-6068
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 34 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jun 27 1966
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Carroll
10c. City, Town or Location: Westminster
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 442 Silver Court
10f. Zip Code: 21158
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Machine Operator
16b. Kind of Business/Industry: William T. Burnett

17. Father's Name (First, Middle, Last): Franklin Spencer
18. Mother's Name (First, Middle, Maiden Surname): Catherine Myers

19a. Informant's Name/Relationship (Type, Print): Lisa Spencer/wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 442 Silver Ct. Westminster, MD 21158

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Sandymount Church Cem — Date: 3/12/2001
20c. Location - City or Town, State: Sandymount, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Pritts Funeral Home and Chapel, 412 Washington Rd Westminster, MD 21157

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

March 8, 2001 2:00 p.m.
Baltimore, Maryland 21215-0036

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such ea cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Astrocytoma
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last: b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) Hospice

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D43725
29d. Date signed (Month, Day, Year): 3/9/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Tariq Mahmood, 2300 Dulaney Valley Road, Timonium, MD 21093

**State Registrar**

31. Date filed (Month, Day, Year): MAR 12 2001
32. Registrar's Signature: [signature]

Brian Spencer
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WJL 10

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 09006

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Dorothy May Snook | March 10th, 2001 | 3:05 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Carroll County General Hospital | Westminster | Carroll |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-46-6662 | 1☐M 2☒F | 81 Yrs. | | | May 4, 1919 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Carroll | Mt. Airy | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 5150 Perry Rd. | 21771 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12th | | Housewife | Her Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| James Hoffmaster | Bessie Hoffmaster |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Phyllis J. Miller (daughter) | 5150 Perry Rd. Mt. Airy, MD 21771 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Lorraine Park Cem. | 3/14/2001 | Baltimore, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Carol Mellon | Burrier-Queen Funeral Directors, PA 1212 West Old Liberty Rd. Winfield, MD 21784 |

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Pneumonia. | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes, Ischemic Heart disease, dementia, congestive heart failure

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☒No 3☐Probably 4☐Unknown | 1☐Yes 2☒No | 1☐Yes 2☒No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| MD | D48006 | March 10th, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
KOFI BOAITEY, 200 memorial Ave, Westminster, MD 21157

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 12 2001 | Geneva G Sparks |

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Division of Vital Records, P.O. Box 68760,**

Dorothy May Snook

CEW 6

DHMH 17 Rev 1/2001

ORIGINAL

Amend Item 16b per F.D., 03/12/2001, Carroll County, wjl

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 09007

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|
| Lawrence Edgar Schaeffer | Mar | 9 | 2001 | 1820 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Carroll County General Hospital | Westminster | Carroll |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 219-36-0458 | 1☒M 2☐F | 90 Yrs. | | | | | Sept 30 1910 | MD |

**Usual Residence of Decedent**

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Carroll | Westminster | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3025 Homestead Drive | 21158 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 7 | | Orchard Helper | ~~James Langdon Orchard~~ James Langdon Orchard |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Edgar H. Schaeffer | Lizzie Wantz |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Pauline Shaffer/POA | 3025 Homestead Drive Westminster, MD21158 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Kriders Cemetery | 3/13/2001 | Westminster, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| John K. Apple | Fritts Funeral Home and Chapel 412 Washington Road Westminster, MD 21157 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Myocardial infarction | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): Congestive Heart failure | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fatal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

TIA

Basal cell carcinoma

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☐No 3☐Probably 4☒Unknown | 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| John Taylor | D51072 | 3/9/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200 Memorial Ave.
Sharon Taylor Carroll County General Hospital, Westminster, MD 21157

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 12 2001 | Geneva G Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WJL
1

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 09008

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| CATHERINE | H. | TILGHMAN | MARCH 9, 2001 | 9:45P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 415 PINE BLUFF RD | SALISBURY | WICOMICO |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-32-0981 | 1☒ M 2☐ F | 82 Yrs. | | | DEC. 28, 1918 | SOUTH CAROLINA |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | WICOMICO | SALISBURY | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 415 PINE BLUFF RD | 21801 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 5+ | OCCUPATIONAL THERAPIST | STATE OF DELAWARE |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| CHARLES TILGHMAN | ELIZABETH MAGUIRE |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| M. WILLIAM TILGHMAN - BROTHER | 5414 CHERRY HILL LANE SALISBURY, MD 21801 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | CAMBRIDGE CREMATORY | 3/10/2001 | CAMBRIDGE, MARYLAND |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Melissa Kay Haines | 705 E. MAIN ST. BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, complications that caused the death. Do not enter the mode of dying, such es cerdiec or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Finet disease or condition resulting in death) | a. ALZHEIMER'S DEMENTIA | UNKNOWN |
| Due to (or as e consequence of): | b. HISTORY OF SEVERAL CEREBROVASCULAR ACCIDENTS | UNKNOWN |
| Sequentially list conditions, if eny, leading to immediete ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last | c. ATRIAL FIBRILLATION | UNKNOWN |
| Due to (or es a consequence of): | d. DYSLIPIDEMIA | UNKNOWN |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown | 23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | 23d. Date of delivery Month Day Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? 1☐ Yes 2☑ No | 24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No |
|---|---|

**Medical Certification; To Be Completed by Physician/Medical Examiner**

| 25. Was case referred to medical examiner? 1☐ Yes 2☑ No | 28. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 8☐ Other (Specify) |
|---|---|

| 27. Manner of Death 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred |
|---|---|---|---|---|
| | N/A | | | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ MD | D50929 | 3-12-01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
1405 S. DIVISION ST. SALIS. MD. 21804

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 12 2001 | ▶ Deputy B Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4DQ

+16

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09009

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): EDWARD LEE TAYLOR
2. Date of Death (Month, Day, Year): MARCH 13, 2001
3. Time of Death: 11:40 AM
4a. Facility Name (If not institution, give street and number): CHARLOTTE HALL VETERANS HOME
4b. City, Town, or Location of Death: CHARLOTTE HALL
4c. County of Death: ST. MARY'S

**Funeral Director**

5. Social Security Number: 411-42-4690
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): AUGUST 16, 1928
9. Birthplace (State or Foreign Country): TENNESSEE

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: PRINCE GEORGE'S
10c. City, Town or Location: ACCOKEEK
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 14404 LEONARD CALVERT DRIVE
10f. Zip Code: 20607-9747
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: USAF 1946-1966
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MANAGER OPERATING ROOM
16b. Kind of Business/Industry: MEDICAL

17. Father's Name (First, Middle, Last): BEDFORD STANTON TAYLOR
18. Mother's Name (First, Middle, Maiden Surname): EUNA JONES

19a. Informant's Name/Relationship (Type, Print): JOYCE C. TAYLOR/WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14404 LEONARD CALVERT DR., ACCOKEEK, MARYLAND 20607

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): HUNTT CREMATORY
Date: 3/14/2001
20c. Location - City or Town, State: WALDORF, MARYLAND

21. Signature of Funeral Service Licensee: JPK ▶ JOHN P. KNISLEY MD1164
22. Name and Address of Facility: THE HUNTT FUNERAL HOME, INC.,P.O. BOX 156, WALDORF, MARYLAND 20604-0156

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errast, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. BILATERAL PNEUMONIA — FEW DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
ANEMIA
H/O GASTROSTOMY TUBE PLACEMENT
ALZHEIMER DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ATTENING
29c. License number: D 44436
29d. Date signed (Month, Day, Year): MARCH 13 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ASHVINKUMAR I PATEL 102 PAULMEILON CT #102 WALDORF MD 20601

**State Registrar**

31. Date filed (Month, Day, Year): MAR 15 2001
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

011358-003
KYLE TALBOTT
JVW

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

*Certificate of Death*

Reg. No. 2001 09010

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Kyle Brandon Talbott | MARCH 10, 2001 | 03:10 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| in front of 6231 TALBOTT ROAD | LOTHIAN | ANNE ARUNDEL |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220 17 1027 | 1 X M 2 ☐ F | 23 Yrs. | | | April 23, 1977 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Anne Arundel | Lothian | 1 ☐ Yes 2 X No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 6231 Talbott Road | 20711 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 X No If Yes, Give Yaar or Dates: | 1 ☐ Yes 2 X No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | plumbing apprentice | construction |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Shearman James Talbott | Karleen Jeane Stearlings |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Shearman J. Talbott, father | same as # 10 a-f above |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Metropolitan Crematory | 3-12-01 | Alexandria, VA |

21. Signature of Funeral Service Licensee ▶ William R Gross

22. Name and Address of Facility: Rausch Funeral Home, P.A., Owings, MD 20736

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused tha death. Do not enter the mode ot dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediete Cause (Final disease or condition resulting in death) | a. INTRAORAL SHOTGUN WOUND | |
| Sequentlelly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Data of delivery Month Day Year |
|---|---|---|
| 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time ot death 5 ☐ Other (specify) 9 ☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the ceuse ot death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| X Yes 2 ☐ No | 1 ☐ Yes 2 ☐ No |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

25. Was case referred to medical examiner? 1 X Yas 2 ☐ No

28. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) SCENE

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 X Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 26c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| 3/10/01 | 1:38 A M | 1 ☐ Yes 2 X No | SUBJECT SHOT SELF |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| OUTSIDE HOME | 6231 TALBOTT ROAD LOTHIAN, MD |

29a. Certifier (Check only one): 1 ☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X **Medical Examinar**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha ceuse(s) and manner stated.

| 29b. Signatura and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ J. M. T. | O.C.M.E. | MARCH 10, 2001 |

30. Name and address ot person who completed cause ot death (Item 23a) (Type, Print): JACK M. TITUS, M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 12 2001 | ▶ Geneva G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 09011

**Physician /Medical Examiner**

1. Decedent's Neme *(First, Middle, Last)*: JUNE A. VAUGHAN
2. Date of Deeth Month: 3 Day: 10 Yeer: 2001
3. Time of Deeth: 0215
4e. Feciity Neme *(If not institution, give street and number)*: 912 N. FORREST TRAIL
4b. City, Town, or Location of Death: CROWNSVILLE
4c. County of Deeth: ANNE ARUNDEL

**Funeral Director**

5. Sociel Security Number: 200-14-2856
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 75 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Day, Year)*: 5-13-25
9. Birthpiece *(State or Foreign Country)*: PA.

Usuel Residence of Decedent

10a. Stete: MD.
10b. County: WORCESTER
10c. City, Town or Location: OCEAN CITY
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 6 BAY VISTA DRIVE
10f. Zip Code: 21842
10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Merried 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Bleck, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondary (0-12): 12 — College (1-4or 5+):
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Fether's Neme *(First, Middle, Last)*: GEORGE RIELAND
18. Mother's Neme *(First, Middle, Meiden Surname)*: ANASTASIA I. McCOY

19e. Informent's Neme/Reletionship *(Type, Print)*: THOMAS VAUGHAN JR.
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 912 N. FORREST TRAIL CROWNSVILLE, MD21032

20e. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other place)*: SALISBURY CREMATORY
Dete: 3-13
20c. Location - City or Town, State: SALISBURY, MD.

21. Signature of Funeral Service Licensee: John D. Ullrich
22. Neme and Address of Feciity: ULLRICH FUNERAL HOME BERLIN, MD. 21811

**Physician /Medical Examiner**

23a. Part I. Enter the diseese, or complicetions thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heert failure. List only one ceuse on eech line. — Approximete Interval Between Onset end Deeth

Immediete Cause (Finel diseese or condition resulting in deeth): e. Breast cancer with metastasis to lung and bone
Due to (or es e consequence of):
Sequentielly list conditions, if eny, leeding to Immediete cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Last: b.
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No
26. Plece of Deeth *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* Son's home

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined
28e. Dete of Injury *(Month, Day Yeer)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, fectory, offica building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: Bill Green, MD
29c. License number: D-35764
29d. Dete signed *(Month, Day, Year)*: 3/12/01

30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print): Bill Green, MD 124 N. Main Street Berlin, Md. 21811

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 12 200[illegible]
32. Registrar's Signeture: Geneva B. Sparks

10

DHMH 16 Rev 6/95

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2001 09012

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: MILDRED VALLIANT
2. Date of Death Month / Day / Year: MARCH 2 2001
3. Time of Death: 9:28AM
4a. Facility Name *(If not institution, give street and number)*: CORSICA HILLS NURSING HOME
4b. City, Town, or Location of Death: CENTREVILLE
4c. County of Death: QUEEN ANNE

**Funeral Director**

5. Social Security Number: 216-07-7125
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 99 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: JUNE 9, 1901
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: QUEEN ANNE'S
10c. City, Town or Location: CENTREVILLE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 210 THOMAS ROAD
10f. Zip Code: 21617
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yas 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grada completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): -0-
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name *(First, Middle, Last)*: EDWIN STEPHENS VALLIANT
18. Mother's Name *(First, Middle, Maiden Surname)*: NELLIE HALL

19a. Informant's Name/Relationship *(Type, Print)*: JAMES W. VALLIANT/ BROTHER
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 220 THOMAS ROAD, CENTREVILLE, MD 21617

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Nama of cemetery, crematory or other place)*: CHESAPEAKE CREMATION CTR
Date: 3-3-2001
20c. Location - City or Town, State: STEVENSVILLE, MD

21. Signature of Funeral Service Licensee: [signature] CFSP
22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only one cause on each lina.

| | | Approximate Interval Batwaen Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition rasulting in death) a. | bronchial infection | days |
| Due to (or as a consequence of): b. | hypoxemia | days |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last — Due to (or as a consequence of): c. | coronary artery disease | 4 years |
| Due to (or as a consequence of): d. | atrial fibrillation | 4 years |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Kathleen Hoey
29c. Licansa number: D47627
29d. Date signed *(Month, Day, Year)*: 3-2-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KATHLEEN HOEY, M.D., 207 N. LIBERTY ST., CENTREVILLE, MD 21617

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 0 6 2001
32. Registrar's Signature: ▶ [signature] G. Sparks

DHMH 16 Rev 6/95

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09013

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): RALPH H. WARD

2. Date of Death (Month, Day, Year): MARCH 11, 2001

3. Time of Death: 12:48 PM

4a. Facility Name (If not institution, give street and number): WATERVIEW HEALTH CARE CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

**Funeral Director**

5. Social Security Number: 218-20-7029

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): SEPT. 9, 1927

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: WICOMICO

10c. City, Town or Location: SALISBURY

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 504 LIBERTY STREET

10f. Zip Code: 21804

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DRIVER

16b. Kind of Business/Industry: TRUCKING COMPANY

17. Father's Name (First, Middle, Last): HARLEY B. WARD

18. Mother's Name (First, Middle, Maiden Surname): MINNIE LONG

19a. Informant's Name/Relationship (Type, Print): THELMA V. COLLINS - SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 289 PAULETTE DRIVE NEWPORT NEWS, VA 23608

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): PARSONS CEMETERY

Date: 3/15/01

20c. Location - City or Town, State: SALISBURY, MARYLAND

21. Signature of Funeral Service Licensee: ▶ B. Reed [illegible], CFSP

22. Name and Address of Facility: 705 E. MAIN ST. BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Progressive supranuclear palsy

Due to (or as a consequence of):

c. Dementia

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Nakum

29c. License number: D470 64

29d. Date signed (Month, Day, Year): 3/11/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): NAEEM 106 PINE BLUFF ROAD SALISBURY MD 21801

**State Registrar**

31. Date filed (Month, Day, Year): MAR 12 2001

32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

---

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4+1 VA DQ

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 09014

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| DORIS | M. | WRIGHT | 3 | 9 | 2001 | 1410 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| PENINSULA REGIONAL MEDICAL CENTER | SALISBURY | WICOMICO |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-03-7944 | 1☐M 2☒F | 86 Yrs. | | | SEPT. 20, 1914 | MARYLAND |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | WICOMICO | SALISBURY | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 9288 HICKORY MILL RD | 21801 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | SEAMSTRESS | SHIRT FACTORY |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| LEE MESSICK | ADDIE CROCKETT |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| PATRICIA BARDAVID - DAUGHTER | 11408 OCTAGON CT. FAIRFAX, VA 22038 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | SPRINGHILL MEM. GARD. | 3-12-2001 | HEBRON, MARYLAND |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Melissa Kay Hennig | BOUNDS FUNERAL HOME, INC. 705 E. MAIN ST. SALISBURY, MD 21804 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | PULMONARY EDEMA | 1 DAY |
| Due to (or as a consequence of): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. | CONGESTIVE HEART FAILURE | YEARS. |
| Due to (or as a consequence of): | | |
| c. | | |
| Due to (or as a consequence of): | | |
| d. | | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnency | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION
OSTEOPOROSIS

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of causa of death? |
|---|---|---|
| 1☐Yes 2☒No 3☐Probably 4☐Unknown | 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of Certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ MOHAN BHAT, MD | D0055006 | 3/09/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mohan Bhat 711 College Lane Salisbury, Md. 21804

| State Registrar | 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|---|
| | MAR 12 2001 | ▶ Penina B Sparks |

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Doris Wright

2 DQ

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09015

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): JOSEPH DUDLEY WALTON, SR.

2. Date of Death — Month: March, Day: 8, Year: 2001

3. Time of Death: 2:00 p.m.

4a. Facility Name (If not institution, give street and number): 1025 Doris Drive

4b. City, Town, or Location of Death: Owings

4c. County of Death: Calvert

**Funeral Director**

5. Social Security Number: 579 12 3867

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 82 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 19, 1918

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Calvert

10c. City, Town or Location: Owings

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 1025 Doris Drive

10f. Zip Code: 20736

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1943-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): materials & supply agent

16b. Kind of Business/Industry: U.S. Government

17. Father's Name (First, Middle, Last): Eugene Wilson Walton, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Edith Mae King

19a. Informant's Name/Relationship (Type, Print): Rose E. Walton (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): same as 10a/f above

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Southern Mem. Gardens

Date: 3-12-01

20c. Location - City or Town, State: Dunkirk, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Rausch Funeral Home, Owings, MD 20736

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. AMYOTROPHIC LATERAL SCLEROSIS — 4 yrs.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D38563

29d. Date signed (Month, Day, Year): March 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Wayne Bierbaum, M.D. 134 Owensville Rd., West River, MD 20778

**State Registrar**

31. Date filed (Month, Day, Year): MAR 09 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

1 VA 15

01-1308-009
crn
Tyra J. Wert

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

2001 09016
Reg. No.

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Tyra Joseph Wert | March 07 2001 | 5:06 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Calvert Memorial Hospital | Prince Frederick | Calvert |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216 40 5328 | 1 [X] M 2 [ ] F | 57 Yrs. | | | Aug. 22, 1943 | MD |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Anne Arundel | Friendship | 1 [ ] Yes 2 [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 11501 Cornwall Road | 20758 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced | 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: | 1 [ ] Yes 2 [X] No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | machinist | tool & die |
| | 2 | | |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| William Vaughn Wert | Florence Thatcher Filor |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Nicole C. Windsor (daug.) | 7814 DeForest Drive, Chesapeake Beach, Md 20732 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) entombment | Resurrection Cem. | 3-12-01 | Clinton, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| [signature] | Rausch Funeral Home, Owings, MD 20736 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | Hypertensive Arteriosclerotic Cardiovascular Disease | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. Due to (or as a consequence of): | |
| | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1 [ ] Yes 2 [ ] No 9 [ ] Unknown | 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No — ns.

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1 [ ] Yes 2 [ ] No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] J. Pestaner, M.D. | O.C.M.E. | March 08, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Pestaner, M.D. 111 Penn Street, Baltimore, Maryland 21201

12

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 09 2001 | [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09017

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Edna Weir

2. Date of Death — Month: March Day: 13 Year: 2001

3. Time of Death: 7:00 AM

4a. Facility Name *(If not institution, give street and number)*: Genesis ElderCare - The Pines

4b. City, Town, or Location of Death: Easton

4c. County of Death: Talbot

**Funeral Director**

5. Social Security Number: 221-12-8353A

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 77 Yrs.

If Under 1 Year — Months: Days: If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: November 7, 1923

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Caroline

10c. City, Town or Location: Federalsburg

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 618 Liberty Road

10f. Zip Code: 21632

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Caucasian

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 HS Grad. College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Secretary

16b. Kind of Business/Industry: Newspaper

17. Father's Name *(First, Middle, Last)*: Myrl Atlee Montgomery

18. Mother's Name *(First, Middle, Maiden Surname)*: Ola Elizabeth Chaffinch

19a. Informant's Name/Relationship *(Type, Print)*: William Harold Weir Husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 618 Liberty Road, Federalsburg, Maryland 21632

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Spring Hill Cemetery

Date: 3/16/01

20c. Location - City or Town, State: Easton, Maryland

21. Signature of Funeral Service Licensee: Raeford L. Moore

22. Name and Address of Facility: Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cerebral thrombosis — 2-18-01

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Systemic lupus erythematosus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robert W. Trever, M.D.

29c. License number: D0010938

29d. Date signed *(Month, Day, Year)*: 03-13-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROBERT TREVER MD 7696 OCEAN GATEWAY EASTON, MD 21601

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 15 2001

32. Registrar's Signature: Geneva D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

Edna Weir

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

**To be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09018

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ANNA YARUP
2. Data of Death: Month 3 Day 5 Year 2001
3. Time of Death: 9:30 AM
4a. Facility Name (If not institution, give street and number): #404 The Waves 136th St.
4b. City, Town, or Location of Death: Ocean City
4c. County of Death: Worcester

**Funeral Director**

5. Social Security Number: 190-28-7585
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 94 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12/31/1906
9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4230 Darleigh RD
10f. Zip Code: 21236
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Educetion (Specify only highest grede completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Neme (First, Middle, Last): John Guffrey
18. Mother's Neme (First, Middle, Maiden Surneme): Mary Lecorchick

19a. Informant's Name/Relationship (Type, Print): Richard Yarup/ Son
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 327 South Taylor Ave. Baltimore, MD 21221

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or othar piece): LaFayette Memorial Park | Date: 3/10/01
20c. Location - City or Town, State: Brier Hill, PA

21. Signature of Funeral Service Licensee: W. Fred Burbage
22. Name and Address of Facility: Burbage Funeral Home 108 William St. Berlin, MD 21811

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Coronary Artery Disease
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.
Congestive Heart Failure
Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Son's Home
27. Menner of Death: 1☑ Natural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Streat and Number or Rural Routa Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Deborah L Gallo
29c. Licansa number: H0055992
29d. Date signed (Month, Dey, Year): 03/07/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Deborah L Gallo DO 6730 Holabird Ave Baltimore, MD 21222

**State Registrar**

31. Data filed (Month, Day, Year): MAR 09 2001
32. Registrar's Signature: Donna G. Sparks

7

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by tha funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 09019

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ASHLEY ALSTON

2. Date of Death: Month March Day 12 Year 2001

3. Time of Death: 638 A M

4a. Facility Name (If not institution, give street and number): University of Maryland Medical

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

**Funeral Director**

5. Social Security Number: none

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min. 45

8. Date of Birth (Month, Day, Year): Mar 12, 2001

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 6200 Carbore Way Baltimore

10f. Zip Code: 21214

10g. Citizen of What Country? USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): none; College (1-4or 5+): none

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): none

18b. Kind of Business/Industry: none

17. Father's Name (First, Middle, Last): unk

18. Mother's Name (First, Middle, Maiden Surname): Ingrid E. Lewis

19a. Informant's Name/Relationship (Type, Print): UMMS

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 22 S. Greene Street Baltimore, MD 21201

20e. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place):

Date:

20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Extreme Preematurity

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Diseese or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequenca of):

d.

IF FEMALE:

23b. Was decedent pregnant in tha past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnency: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Data of delivery: Month Day Year

Part II. Dthar significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Sandip Patel

29c. License number: D55511

29d. Date signed (Month, Day, Year): March 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SANDIP PATEL 22 South Greene St, Baltimore, Maryland 21201

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

**State Registrar**

31. Date filed (Month, Day, Year): MAR 26 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09020

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Mabel K. Ammon
2. Date of Death (Month, Day, Year): March 22, 2001
3. Time of Death: 10:40 p.m.
4a. Facility Name (If not institution, give street and number): 3614 Frankford Avenue
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 213-26-3822
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 87 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 5, 1913
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3614 Frankford Avenue
10f. Zip Code: 21214
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 yrs. — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Assistant Buyer
16b. Kind of Business/Industry: Department Store

17. Father's Name (First, Middle, Last): Charles A. Hasslinger
18. Mother's Name (First, Middle, Maiden Surname): Marie W. Augsburger

19a. Informant's Name/Relationship (Type, Print): Mabel A. Cranidiotis / Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3614 Frankford Avenue Baltimore, Maryland 21214

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery
Date: 3/26/2001
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Michael E. Canapp — ▶ M. E. Canapp
22. Name and Address of Facility: 5305 Harford Road — Leonard J. Ruck, Inc. Baltimore, MD 21214

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Carcinoma - Unknown Primary — 2 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 8☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Davis M. Hahn
29c. License number: D20398
29d. Date signed (Month, Day, Year): March 23, 2001
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Davis M. Hahn 5601 Loch Raven Blvd Balto. Md 21239

**State Registrar**

31. Date filed (Month, Day, Year): MAR 2 6 2001
32. Registrar's Signature: ▶ Deputy

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed, filed by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Amended Item#10d perFH,#24a perVERBALG793 3/26/2001 EW

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

2001 09021 Reg. No.

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Data of Death Month | Day | Year | 3. Time of Daath |
|---|---|---|---|---|---|---|
| DonalD E | Andrews | | February | 21 | 2001 | 11:16 M |

| 4a. Facility Nama (If not institution, give street and number) | 4b. City, Town, or Location of Daath | 4c. County of Death |
|---|---|---|
| The Johns Hopkins Hospital | Baltimore City | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 225-86-7069 | 1☒M 2☐F | 43 Yrs. | | | June 1, 1957 | Virginia |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. Stata | 10b. County | 10c. City, Town or Location | 10d. Insida City Limits |
|---|---|---|---|
| Virginia | Warren | Front Royal | 1☐Yas 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizan of What Country? |
|---|---|---|
| 1278 Kendrick Ford Road | 22630 | U.S.A. |

| 11. Marital Status | 12. Wes Decedent Evar in U.S. Armed Forces? | 13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuben, Mexican, Puarto Rican, atc.) | 14. Rece - American Indian, Black, Whita, atc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yas 2☒No If Yes, Give Year or Dates: | 1☐Yas 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) | 18b. Kind of Businass/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Contractor | Air Conditioning |

| 17. Father's Name (First, Middle, Last) | 18. Mothar's Nama (First, Middle, Maiden Surname) |
|---|---|
| Donald Earl Andrews, Sr. | Helen Virginia Knight |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Pamela M. Andrews: Wife | 1278 Kendrick Ford Rd; Front Royal, Va. 22630 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Data | 20c. Location - City or Town, Stete |
|---|---|---|---|
| 1☐Burial 2☐Cremation 3☐Removal from Stata 4☐Donation 5☐Other (Specify) | Panorama Mem. Gardens | 2/24/2001 | Waterlick, Va. |

| 21. Signature of Funeral Service Licensee | 22. Nama and Addrass of Facility |
|---|---|
| Bryan L. Fleeks | Turner-Robertshaw Funeral Home; Front Royal, Va. |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complicetions thet caused the death. Do not antar tha moda of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one causa on each lina.

Approximata Intarval Batween Onsat and Death

| | | |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Left chest Bleeding | 20 minutes |
| Dua to (or as a consequence of): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. | Rhizopus Pneumonia | Months |
| Dua to (or as a consequence of): | | |
| c. | Renal Transplant | Months |
| Dua to (or as a consequence of): | | |
| d. | End staye Renal Disease | Years |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcoma of pragnancy | 23d. Data of dalivary Month / Day / Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fatal death 3☐Ectopic pregnancy 4☐Pregnant at tima of deeth 5☐Othar (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contnbuting to death but not rasulting in tha undarlying causa givan in Part I.

| 23e. Did tobacco usa contributa to the cause of daath? | 24a. Was an autopsy performed? | 24b. Wera autopsy findings available prior to completion of causa of daath? |
|---|---|---|
| 1☐Yes 2☒No 3☐Probably 4☐Unknown | 1☐Yas 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medicat examiner? | 26. Placa of Daath (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residance 6☐Othar (Specify) |

| 27. Manner of Death | 28a. Data of Injury (Month, Day Year) | 28b. Tima of Injury | 28c. Injury at Work? | 28d. Dascribe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yas 2☐No | |
| | 28e. Place of Injury - At homa, farm, straet, factory, office building, atc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one)

1☒ **Certifying Physician:** To tha best of my knowledge, death occurred at tha tima, data and place, and due to tha causa(s) and mannar as stated.

2☐ **Medical Examiner:** On the basis of axamination and/or investigation, in my opinion, death occurred at tha tima, data and placa, and dua to tha causa(s) and mannar stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Data signed (Month, Day, Yaar) |
|---|---|---|
| T. Ponsky MD | Res-000 | February 21, 2001 |

30. Name and address of person who completed cause of daath (Item 23a) (Type, Print)

Todd Ponsky Johns Hopkins 600 North Wolfe Street

**State Registrar**

| 31. Deta filed (Month, Day, Year) | 32. Registrar's Signatura |
|---|---|
| MAR 26 2001 | G Spotts |

**To the Hospital or Attending Physician:** The law requires thet the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

#10D #24A

DHMH 17 Rav 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09022

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Linda Dermott Bork
2. Date of Death (Month, Day, Year): March 20, 2001
3. Time of Death: 6:50 PM
4a. Facility Name (If not institution, give street and number): 13000 A Dulaney Valley Road
4b. City, Town, or Location of Death: Long Green
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 216-50-3025
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 53 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12/10/1947
9. Birthplace (State or Foreign Country): N.Y.

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Long Green
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 13000 A Dulaney Valley Road
10f. Zip Code: 21092
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Seamstress
16b. Kind of Business/Industry: Self employed

17. Father's Name (First, Middle, Last): Charles Dermott
18. Mother's Name (First, Middle, Maiden Surname): Beverly Ann Chambers

19a. Informant's Name/Relationship (Type, Print): Andrea Meyer / daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1773 E. Millcreek Way; Salt Lake City, Utah 84106

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Service Corp
Date: 3/24/01
20c. Location - City or Town, State: Towson, MD

21. Signature of Funeral Service Licensee: Peter V. Ruck
22. Name and Address of Facility: Ruck Towson Funeral Home Inc. 1050 York Road Towson, MD 21204

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Strangulation from Hanging
Due to (or as a consequence of): b.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: Due to (or as a consequence of): c.
Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☑ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year): March
28b. Time of Injury: AM
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: Hung Self
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): At Home
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☑ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Charles F O'Donnell MD
29c. License number: D-09383
29d. Date signed (Month, Day, Year): March 21, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Charles F. O'Donnell MD 11 Hamlet Hill Rd Baltimore Md 21210

**State Registrar**

31. Date filed (Month, Day, Year): MAR 2 6 2001
32. Registrar's Signature: Geneva G Sparks

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

**To Be Completed by Funeral Director**

DHMH 16 Rev 6/95

ORIGINAL

CPS Dwayne Burke
01-1542-510
UNKNOWN 01-062

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

2001 09023
Reg. No.

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| DWAYNE Burke | March 19, 2001 | 2:24 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Sinai Hospital | Baltimore | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-94-2816 | 1 X M 2 ☐ F | 36 Yrs. | | | Feb. 4, 1965 | maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md. | N/A | Baltimore | 1 X Yes 2 ☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 6737 Liberty Hts. Ave | 21215 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 X No If Yes, Give Year or Dates: | 1 ☐ Yes 2 X No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | Home Improver | Home Improving |
| 12th | N/A | | |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Hubert V. Burke | Shirley L. Locust |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Shirley B. Lester - mother | 3749 Brice Run Rd. Randallstown, md. 21133 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Mount Zion cem. | 3/27/01 | Lansdowne, md. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Lewis T. Gwynn | Lewis T. Gwynn Funeral Home 4517 Park Heights Ave. Balto. md. 21215 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Multiple gunshot wounds | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 X Yes 2 ☐ No | 1 X Yes 2 ☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 X Yes 2 ☐ No | Hospital: 1 ☐ Inpatient 3 X ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 X Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 3-19-2001 | 1337 M | 1 ☐ Yes 2 X No | subject was shot by police officiers |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| Street | 4400 N. Towanda Baltimore City, Maryland |

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Stephen S. Radentz, M.D. | OCME | March 20, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 26 2001 | ▶ B. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

01-1508-510
B.K.S
GEORGE BUTLER

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM 23a,ptII per ME G794 041701 SS

# Certificate of Death

2001 09024 Reg. No.

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): George R. Butler
2. Date of Death: Month MARCH Day 17, Year 2001
3. Time of Death: 1538 P M
4a. Facility Name (If not institution, give street and number): 1728 DRUID HILL AVENUE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 217-62-1828
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 46 Yrs. If Under 1 Year: Months, Days. If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Jan. 23, 1955
9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: md. 10b. County: N/A 10c. City, Town or Location: Baltimore 10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 1514 Eutaw Place 10f. Zip Code: 21217 10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes: Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Asbestos / Led worker
16b. Kind of Business/Industry: A-L. Abatement Inc.

17. Father's Name (First, Middle, Last): George R. Butler
18. Mother's Neme (First, Middle, Meiden Sumame): Thelma E. Rodgers

19e. Informant's Name/Relationship (Type, Print): Carrie M. Butler - Wife
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 1514 Eutaw Place. Balto. md. 21217

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, crematory or other place): Garrison Forest Vet. Date: 3/26/01
20c. Location - City or Town, State: Owings Mills, md.

21. Signature of Funerel Service Licensee: Lewis T. Gwynn — Lewis T. Gwynn
22. Neme and Address of Fecility: Lewis T. Gwynn Funeral Home 4517 Park Heights Ave. Balto. md. 21215

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. DIABETIC KETOACIDOSIS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of deeth 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

23e. Did tobacco use contribute to the causa of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown
24a. Was an autopsy performed? 1 ☒ Yes 2 ☐ No
24b. Were eutopsy findings available prior to completion of cause of death? 1 ☒ Yes 2 ☐ No

25. Was cese referred to medical examiner? 1 ☒ Yes 2 ☐ No
28. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) AT SCENE

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner:** On the besis of exemination and/or investigation, in my opinion, deeth occurred at the time, dete and piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Theodore M. King MD
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): MARCH 18, 2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): THEODORE M. King 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): MAR 26 2001
32. Registrar's Signature: [illegible]

DHMH 17 Rev 1/2001

ORIGINAL

01-1269-510
KARL BURNETT
ASP

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM 1,23a,&27 per ME G794 040201 SS

# Certificate of Death

Reg. No. 2001 09025

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| ~~KARL BURNETTE~~ Karl Burnett | MARCH 06 2001 | 9:00 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| SINAI HOSPITAL | BALTIMORE | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-90-1404 | 1 ~~M~~ 2 F | 37 Yrs. | | | NOV. 21, 1963 | GERMANY |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| md | N/A | Baltimore | 1 ~~Yes~~ 2 No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 5522 Belle Ave | 21207 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ~~Never Married~~ 2 Married 3 Widowed 4 Divorced | 1 Yes 2 ~~No~~ If Yes, Give Year or Dates: | 1 Yes 2 ~~No~~ Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12th | | medical Technologist | Hospitals |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Vernon W. Burnett JR. | Gloria Stent |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Gloria S. Burnett - mother | 5522 Belle Ave Balto. md. 21207 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ~~Burial~~ 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | Woodlawn Cem. | 3-13-01 | Baltimore, md |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ~~Lewis T. Gwynn~~ Lewis T. Gwynn | LEWIS T. Gwynn Funeral Home 4577 Park Heights Ave. Balto. md. 21215 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. MENINGITIS | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown | 23d. Date of delivery Month Day Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1 Yes 2 ~~No~~ 3 Probably 4 Unknown | 1 ~~Yes~~ 2 No | 1 ~~Yes~~ 2 No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 ~~Yes~~ 2 No | Hospital: 1 Inpatient 2 ~~ER/Outpatient~~ 3 DOA | Other: 4 Nursing Home 5 Residence 6 Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 ~~Natural~~ 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | M | 1 Yes 2 No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ~~**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.~~

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ~~Stephen S. Radentz, M.D.~~ | O.C.M.E | MARCH 07, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 26 2001 | ~~Linda G. Sparks~~ |

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 09026

Montel Bernard Rasard Booker 'A'

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: MONTEL Bernard Rasard BOOKER
2. Date of Death Month / Day / Year: MARCH 22 2001
3. Time of Death: 6:25 P.M.
4a. Facility Name *(If not institution, give street and number)*: GREATER BALTIMORE MEDICAL CENTER
4b. City, Town, or Location of Death: TOWSON
4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 215-94-4349
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)* Yrs.: If Under 1 Yaar Months / Days: 2; If Under 24 Hrs. Hours / Min.:
8. Date of Birth *(Month, Day, Year)*:
9. Birthplace *(State or Foreign Country)*: maryland

Usual Residence of Decedent

10a. State: md
10b. County: Baltimore
10c. City, Town or Location: Cockeysville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1066 MistyLynn Circle
10f. Zip Code: 21030
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): N/A; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Infant
16b. Kind of Business/Industry: N/A

17. Father's Name *(First, Middle, Last)*: William Bolden
18. Mother's Name *(First, Middle, Maiden Surname)*: Dorthea michelle Booker

19a. Informant's Name/Relationship *(Type, Print)*: Dorthea M. Booker- mother
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1066 Misty Lynn Circle Cockeysville, md. 21030

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Removel from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Piney Grove U.m. church cem. Date: 3/31/01
20c. Location - City or Town, State: Cockeysville, md.

21. Signature of Funeral Service Licensee: Lewis T. Gwynn ▶ Lewis T. Gwynn
22. Name and Address of Facility: Lewis T. Gwynn Funeral Home 4517 Park Heights ave. Balto md. 21215

**Physician /Medical Examiner**

23e. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediete Ceuse (Final disease or condition resulting in death) e. | Heart Failure | One Day |
| | Due to (or as a consequenca of): Severe Asphyxia In A Premature Infant | Few Weeks |
| Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last b. | Due to (or as a consequence of): Severe Intrauterine Growth Retardation | Several Wks. |
| c. | Due to (or as a consequence of): | |
| d. | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Pulmonary Hypertension

Pulmonary Hemorrhage

Grade IV Intraventricular Hemorrhage

23b. Did tobacco use contributa to the causs of death? 1 [ ] Yss 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No

24b. Were autopsy findings available prior to completion of causa of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] NX

26. Placa of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Menner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending invastigetion 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end piece, and due to the ceuse(s) and menner as stated. 2 [ ] **Medical Examiner:** On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, dete and place, and due to the cause(s) end manner steted.

29b. Signature and title of certifier: ▶ Sabah Helou
29c. Licansa number: D003718
29d. Date signed *(Month, Day, Year)*: 03-23-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sabah Helou, GBMC Hospital, 6701 N. Charles ST. Baltimore 21204

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 26 2001
32. Registrar's Signature: ▶ Barbara B. Sparks

DHMH 16 Rev 6/95

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ADH
KENDALL BOWMAN
01-1514-510

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar AMEND ITEM 23a,27,28a-f per ME G795 051601 SS

Reg. No. 2001 09027

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|
| Kendall | Bowman | MARCH 17, 2001 | 1937 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| JOHNS HOPKINS HOSPITAL | BALTIMORE CITY | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-59-8894 | 1☒M 2☐F | Yrs. | 4 | | Nov. 8, 2000 | maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| md. | N/A | Baltimore | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1 # Polaris Ct. Apt K | 21234 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | Infant | N/A |
| N/A | N/A | | |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Kendall Lamont Bowman SR | Alanda Denise Haggins |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Alanda Haggins – mother | 1 # Polaris Ct. Apt K. Balto md. 21234 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | mount zion cem | 3/24/01 | Lansdowne, md |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Lewis T. Gwynn ▶ Lewis T. Gwynn | LEWIS T. Gwynn Funeral Home 4517 Park Heights Ave. Balto. md. 21215 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

| | | |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. MULTIPLE BLUNT FORCE INJURIES OF THE HEAD AND NECK COMPLICATING MENINGITIS | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnent at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☒Yes 2☐No | 1☒Yes 2☐No |

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) | |
|---|---|---|
| 1☒Yes 2☐No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☐Natural 2☐Accident 3☐Suicide 4☒Homicide 5☐Pending investigation 6☐Could not be determined | 3-17-01 | 7:37 PM | 1☐Yes 2☒No | subject was struck |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| residence | 1 Polaris Court, Baltimore, MD |

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Theodore M. King MD | OCME | MARCH 18, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
THEODORE M. King 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 26 2001 | Gerdine G. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09028

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Irma M. Bohlman
2. Data of Death: Month March Day 25, Year 2001
3. Time of Death: 5:05 AM
4a. Facility Name (If not institution, give street and number): Genesis Eldercare
4b. City, Town, or Location of Death: Severna PArk
4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 220-24-4708
6. Sex: 1☐ M 2☒ F XX
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Mar. 13, 1914
9. Birthplace (State or Foraign Country): Denmark

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Glen Burnie
10d. Inside City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 102 Cedarcliff Court
10f. Zip Code: 21060
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yas 2☒ No XX If Yes, Giva Year or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, atc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Businass/Industry: Own Home

17. Father's Nama (First, Middle, Last): Arel Martin Nielsen
18. Mother's Nama (First, Middle, Maiden Surnama): Sara Greta Kolze

19a. Informant's Name/Relationship (Type, Print): Constance Meece/Daughter
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 102 Cedarcliff Court Glen Burnie, MD 21060

20a. Method of Disposition: XX Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Nama of cemetery, crematory or other place): Glen HAven Mem. Pk. Mar 28, 2001
20c. Location - City or Town, Stata: Glen Burnie, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Kirkley-Ruddick Funeral Home P.A. 421 Crain Hwy. S.E. Glen Burnie, MD 21061

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on aach lina.

Approximata Interval Batween Onsat and Death

Immediate Cause (Final disease or condition resulting in death): e. CEREBROVASCULAR ACCIDENT — 2 WEEKS

Dua to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Dua to (or as a consequence of):
c. Dua to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying causa given in Part I.: DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No XX
24b. Wara autopsy findings available prior to completion of causa of death? 1☐ Yes 2☐ No

25. Was casa refarred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only ona): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Homa 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural XX 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, data and place, end due to tha cause(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or Investigation, in my opinion, death occurred at the time, date and piece, and due to tha cause(s) and mannar stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D21776
29d. Data signed (Month, Day, Year): March 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Suryia P. Mundra, MD 3001 Hanover Street Baltimore, MD 21225 Suite 202

**State Registrar**

31. Date filed (Month, Day, Year): MAR 26 2001
32. Registrar's Signatura: [signature]

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 09029

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|---|---|
| Olive | | Baker | March 21, 2001 | 11:52 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| University of Maryland Medical System | Baltimore | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-07-3316 | 1☐M 2☒F | 81 Yrs. | | | April 04, 1919 | Mass. |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD. | Anne Arundel | Pasadena | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1732 Grandview Road | 21122 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Social Security Administration | Social Security |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| George H. Whittingham | Olive Fellows |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Nancy Higgins - daughter | 560 Grays Creek Rd., Pasadena, MD., 21022 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Balt., Nat'l. Cemetery | 03-23 2001 | Baltimore, MD. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] | Witzke Funeral Home/Catonsville 1630 Edmondson Ave., Catonsville, MD., 21228 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Massive Pulmonary Embolism | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery (Month, Day, Year) |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Aortic Aneurysm

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] MD | AU 4176435 | March 22, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David Hager MD, 22 South Greene St., Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 26 2001 | ▶ [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

**Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

2001 09030

# Certificate of Death

Reg. No.

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ERMA ZELDA BRESSLER

2. Date of Death (Month, Day, Year): MARCH 19, 2001

3. Time of Death: 8:00 AM

4a. Facility Name (If not institution, give street and number): LEVINDALE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 218-12-7998

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JUNE 20,1923

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: ☒ Yes 2☐ No

10e. Street and Number: 2434 W. BELVEDERE AVENUE

10f. Zip Code: 21215

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married ☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): OFFICE MANAGER

16b. Kind of Business/Industry: CLOTHING

17. Father's Name (First, Middle, Last): JACK RHODY

18. Mother's Name (First, Middle, Maiden Surname): JENNIE EPSTEIN

19a. Informant's Name/Relationship (Type, Print): EILEEN CHIAT / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7 QUERN COURT - OWINGS MILLS, MD 21117

20a. Method of Disposition: ☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crametory or other place): MIKRO KODESH BETH ISRAEL

Date: 3/21/01

20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: Jay Alan Lewis

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia — days

Due to (or as a consequence of):

b. Alzhemer's disease — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Peripheral Vascular Disease

Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Susan M Levy DO

29c. License number: D33943

29d. Date signed (Month, Day, Year): 3/19/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Susan M Levy DO Levindale

**State Registrar**

31. Date filed (Month, Day, Year): MAR 26 2001

32. Registrar's Signature: D Sparks

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09031

218-20-5429

George Croswell

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|
| GEORGE W. CROSWELL SR | March 16, 2001 | 2252 |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| PENINSULA REGIONAL MEDICAL CENTER | SALISBURY | WICOMICO |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-20-5429 | 1☒ M 2☐ F | 74 Yrs. | | | Aug 12, 1926 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Somerset | Marion Station | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 5098 Cornstack Road | 21838 | USA |

| 11. Marital Status | 12. Wes Decedent Evar in U.S. Armed Forces? | 13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) | 14. Rece - American Indian, Bleck, White, etc. |
|---|---|---|---|
| 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☒ Yes 2☐ No If Yes, Give Yaer or Detes: | 1☐ Yes 2☒ No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementery/Secondary (0-12) | College (1-4or 5+) | electrician | delmarva power & light |
| 7 | 0 | | |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Neme (First, Middle, Maiden Surname) |
|---|---|
| Willard Randall Croswell | Louise Pusey |

| 19a. Informent's Neme/Reletionship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Lori Croswell/daughter | 5098 Cornstack Rd Marion Station, MD 21838 |

| 20a. Method of Disposition | 20b. Piece of Disposition (Neme of cemetery, crematory or other piece) | Dete | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Buriel 2☐ Cremation 3☐ Removel from Stata 4☒ Donation 5☐ Other (Specify) | | | |

| 21. Signature of Funeral Service Licensee | 22. Nama end Address of Facility |
|---|---|
| Ronald S. Wade, Director | State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiretory errest, shock, or heert teilure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediete Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

b.

Due to (or es a consequence of):

c.

Dua to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

COPD, respiratory failure

Hiatus Hernia, cardiac arrythmia - Atrial Flutter

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yas 2☒ No

26. Ptece of Deeth (Check only one)

Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending invastigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one)

1☒ **Certifying Phyaician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) and mannar as stated.

2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner steted.

| 29b. Signature and title of certifier | 29c. License number | 29d. Dete signed (Month, Day, Year) |
|---|---|---|
| | 27670 | 3/19/01 |

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) Rev. C. M. Evangelista 105 Pine Bluff Rd #4 Salisbury, MD 21801

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signeture |
|---|---|
| MAR 2 6 2001 | Geneva G Sparks |

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

01-1472-510
jhm
JAMAR
CHILDS

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPENDED 072501: ITEMS# 23a,27,28a-f per ME G797 SS

# Certificate of Death

2001 09032
Reg. No.

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| JAMAR | | CHILDS | MARCH 16, 2001 | 05:50 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| SINAI HOSPITAL | BALTIMORE | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 215-59-1768 | 1 X M 2 ☐ F | Yrs. | 4 | 22 | | | Oct. 22, 2000 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| md. | N/A | Baltimore | 1 X Yes 2 ☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3503 Lucille Ave | 21215 | U.S.A |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 X No If Yes, Give Year or Dates: | 1 ☐ Yes 2 X No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| N/A | N/A | Infant | N/A |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Jamal Childs | Charrise Freeman |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Charrise Freeman - mother | 3503 Lucille Ave. Balto. md. 21215 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | King memorial PK | 3/23/01 | Randallstown, md |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Lewis T. Gwynn Lewis T. Gwynn | LEWIS T. GWYNN Funeral Home 4517 Park Heights Ave. Balto. md. 21215 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. SUDDEN UNEXPECTED DEATH IN INFANCY | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnent in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivary Month / Day / Year |
|---|---|---|
| 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetel death 3 ☐ Ectopic pregnency 4 ☐ Pregnent at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probebly 4 X Unknown

| 24a. Was en autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 X Yes 2 ☐ No | 1 X Yes 2 ☐ No |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

| 25. Wes case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 X Yes 2 ☐ No | Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. Menner of Death | 28a. Dete of Injury (Month, Day, Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 ☐ Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 X Could not be determined | found: 3-16-01 | found: 5:15A M | 1 ☐ Yes 2 X No | unknown |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| residence | 4614 Pimlico Rd., Balto., MD |

29a. Certifier (Check only one)
1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Theodore M. King MD | OCME | MARCH 17, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
THEODORE M. King 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 26 2001 | ▶ Lenora G. Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 09033

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Ethel B. Cross
2. Date of Death: Month March, Day 21, Year 2001
3. Time of Death: 3:10 A.M.
4a. Facility Name (If not institution, give street and number): East Point Nursing Home
4b. City, Town, or Location of Death: East Point
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 220-03-0743
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 98 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12/14/1902
9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1905 Nevill RD
10f. Zip Code: 21222
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
18b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): George Bogner
18. Mother's Name (First, Middle, Maiden Surname): Kathleen Tackas

19a. Informant's Name/Relationship (Type, Print): Charles S. Hagan/Son-In-Law
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1912 Nevill RD Baltimore, MD 21222

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Oaklawn Cemetery
Date: 03/24/2001
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee ▶
22. Name and Address of Facility: Bradley Ashton Matthews Funeral Home, Inc 2134 Willow Spring RD BAltimore, MD 21222

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Arteriosclerotic Heart Disease — > 2 yr

Due to (or as a consequence of):
b. arteriosclerosis — > 2 yr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶
29c. License number: D11150
29d. Date signed (Month, Day, Year): 3/22/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MELITO M. TORRES, MD 441 S. ELLWOOD AVE, BALTO MD 21224

**State Registrar**

31. Date filed (Month, Day, Year): MAR 26 2001
32. Registrar's Signature ▶ Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Ethel Cross

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 09034

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Charles Edward Crompton

2. Date of Death: Month March Day 21 Year 2001

3. Time of Death: 9:45 p M

4a. Facility Name (If not institution, give street and number): 675 Queens Gate Road

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: n/a

**Funeral Director**

5. Social Security Number: 219-18-0007

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov 9 1925

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 675 Queens Gate Road

10f. Zip Code: 21229

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Storeroom Manager

18b. Kind of Business/Industry: Utilities / BGE

17. Father's Name (First, Middle, Last): Richard H. Crompton

18. Mother's Name (First, Middle, Maiden Surname): Rose Schwartz

19a. Informant's Name/Relationship (Type, Print): Muriel Elaine Crompton / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 675 Queens Gate Road, Baltimore, Maryland 21229

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland Veterans Cem.

Date: 3/26/01

20c. Location - City or Town, State: Crownsville, Maryland

21. Signature of Funeral Service Licensee: ▶ Michele N Vetula MO1241

22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PULMONARY FIBROSIS — 13 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Data of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD

29c. License number: D40012

29d. Date signed (Month, Day, Year): MARCH 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SCOTT POULTON, MD ; 700 GRIPE ROAD, CATONSVILLE, MD 21228

**State Registrar**

31. Date filed (Month, Day, Year): MAR 2 6 2001

32. Registrar's Signature: ▶ Brenda D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 09035

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|
| Sheronda Dean | | March | 22, | 2001 | 11:57 AM |
| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | | 4c. County of Death | | |
| Northwest Hospital | Randallstown | | Baltimore | | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 218-74-7219 | 1☐ M 2☒ F | 34 Yrs. | | | | | 07-08-66 | MD |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | NA | Baltimore | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1425 Homestead Street | 21218 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12th Grade | NA | Disabled | Disabled |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Leroy Dean | Francina Robinson |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Myrtle M. Robinson | 1425 Homestead Street Baltimore, Maryland 21218 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Voshell Mem. Gardens | 03-26-01 | Dundalk, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Gladys Warner | Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Uninary Tract infection

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown | 23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | 23d. Date of delivery Month Day Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Mental Retardation

Seizures

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? 1☐ Yes 2☒ No | 24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No |
|---|---|

**Medical Certification; To Be Completed by Physician/Medical Examiner**

| 25. Was case referred to medical examiner? 1☐ Yes 2☒ No | 26. Place of Death (Check only one) Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |
|---|---|

| 27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred |
|---|---|---|---|---|
| | | | | |

| 26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 26f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ MD | D54352 | March 22, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Mircea Todor, MD
Northwest Hospital 5401 Old court Road Randallstown, Maryland 21133

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 2 6 2001 | ▶ Donna G Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09036

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Herman Dillard

2. Date of Death — Month: March Day: 17 Year: 01

3. Time of Death: 9AM

4a. Facility Name (If not institution, give street and number): Garden View Nursing Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

**Funeral Director**

5. Social Security Number: 227-22-6979

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 79 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 31, 1921

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 22 S. Athol Avenue

10f. Zip Code: 21229

10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? unk — 1 [ ] Yes 2 [ ] No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yas 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: black

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): unk — College (1-4or 5+): unk

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unk

16b. Kind of Business/Industry: unk

17. Father's Name (First, Middle, Last): unk

18. Mother's Name (First, Middle, Maiden Surname): unk

19a. Informant's Name/Relationship (Type, Print): Bernice Brogden/first cousin

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1654 Heathfield Rd Baltimore, MD 21239

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify): in state

20b. Place of Disposition (Name of cemetery, crematory or other place):

Date:

20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Squamous cell Carcinoma of neck 6m

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one) — Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Amatun M Haleem MD

29c. License number: D 15503

29d. Date signed (Month, Day, Year): March 19, 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): AMATUN M HALEEM 501 Dolphin st, Balto MD 21217

**State Registrar**

31. Date filed (Month, Day, Year): MAR 2 6 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2001 09037

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: REJETTA DICKENS
2. Date of Death Month: 3 Day: 11 Year: 2001
3. Time of Death: 12:00
4a. Facility Name *(If not institution, give street and number)*: NOBLE HOUSE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

**Funeral Director**

5. Social Security Number: 578-34-3546
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 81 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Apr 14, 1919
9. Birthplace *(State or Foreign Country)*: unk

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2327 North Charles Street
10f. Zip Code: 21218
10g. Citizen of What Country?: USA
11. Marital Status: unk — 1☐ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* black
15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): unk — College (1-4or 5+): unk
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: unk
16b. Kind of Business/Industry: unk
17. Father's Name *(First, Middle, Last)*: unk
18. Mother's Name *(First, Middle, Maiden Surname)*: unk
19a. Informant's Name/Relationship *(Type, Print)*: Noble House
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2327 N. Charles Street Baltimore, MD 21218
20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other *(Specify)* in state
20b. Place of Disposition *(Name of cemetery, crematory or other place)*:
Date:
20c. Location - City or Town, State:
21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

**To Be Completed by Funeral Director**

Rejetta Dickens
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Congestive Heart Failure — 2 wks
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Atherosclerotic Cardiovascular disease — 10 yrs
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Renal insufficiency
Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No
25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)* — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*:
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred:
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*:
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*:

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D38675
29d. Date signed *(Month, Day, Year)*: 3/16/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOEL MESHULAM 301 ST PAUL PL SUITE 605 BALT MD 21202

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 2 6 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09038

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): HARRY EDWARD DILL
2. Date of Death (Month, Day, Year): March 9, 2001
3. Time of Death: 1:30 PM
4a. Facility Name (If not institution, give street and number): 715 Maiden Choice Lane #CC617
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 215-01-3539
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 04, 1914
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10a. Street and Number: 715 Maiden Choice Lane #CC617
10f. Zip Code: 21228
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): +5
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): accounting
16b. Kind of Business/Industry: manufacturing

17. Father's Name (First, Middle, Last): Harry Clinton Dill
18. Mother's Name (First, Middle, Maiden Surname): Addie Mae Cunningham

19a. Interment's Name/Relationship (Type, Print): Verna Dill/spouse
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 715 Maiden Choice Lane #CC617 Baltimore, MD 2122

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place):
Date:
20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. NON-SMALL CELL CARCINOMA RIGHT LUNG — 3 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

EMPHYSEMA. BRAIN METASTASES. COLON CANCER
1993. CEREBROVASCULAR INSUFFICIENCY

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year):
28b. Time of Injury: M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred:
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify):
28f. Location (Street and Number or Rural Route Number, City or Town, State):

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ATTENDING PHYSICIAN
29c. License number: D16200
29d. Date signed (Month, Day, Year):

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): NORBERTO M. MACHIRAN, MD 720-C MAIDEN CHOICE LA. CATONSVILLE, MD 21228

**State Registrar**

31. Date filed (Month, Day, Year): MAR 2 6 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg No. 2001 09039

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: George Fraser Donald, Sr.

2. Date of Death — Month: March Day: 24, Year: 2001

3. Time of Death: 12:17am

4a. Facility Name *(If not institution, give street and number)*: Sinai Hospital of Baltimore

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 218-28-1774

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 68 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: September 9, 1932

9. Birthplace *(State or Foreign Country)*: PA

Usual Residence of Decedant

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Baldwin

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10a. Street and Number: P.O. Box 30

10f. Zip Coda: 21013

10g. Citizen of What Country?: U.S.A.

11. Marifal Status: 1 [ ] Nevar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedant Evar in U.S. Armed Forcas? 1 [ ] Yes 2 [X] No If Yas, Giva Yeer or Dates:

13. Was Decedant of Hispenic Origin? (Specify Yas or No- If Yas, specify Cuben, Maxican, Puarto Rican, atc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - Amarican Indien, Bleck, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highest grada completed)*: Elementary/Secondary (0-12): 10 / College (1-4or 5+): n/a

16a. Decedant's Usuel Occupetion *(Give kind of work dona during most of working life. DO NOT usa retired)*: Elevator mechanic

16b. Kind of Businass/Industry: Union local #7

17. Fethar's Nema *(First, Middle, Last)*: Robert Donald

18. Mothar's Nama *(First, Middle, Meidan Surnema)*: Margaret Fraser

19a. Informant's Name/Reletionship *(Type, Print)*: Robert J. Donald-son

19b. Meiling Address *(Street and Number or Rural Routa Number, City or Town, Steta, Zip Code)*: 7 Marmaduke Court, Baldwin, MD 21013

20a. Mathod of Disposition: 1 [X] Buriai 2 [ ] Cramation 3 [ ] Ramovai from State 4 [ ] Donetion 5 [ ] Othar *(Specify)*

20b. Place of Disposition *(Nama of cematary, crematory or othar placa)*: Moreland Memorial Park

Date: 3/27/01

20c. Location - City or Town, Stata: Baltimore, MD

21. Signature of Funaral Service Licensee: William G. Dau

22. Nama and Addrass of Facility: Leonard J. Ruck Funeral Home, Inc. 5305 Harford Rd., Baltimore, MD 21214

**Physician /Medical Examiner**

23a. Part1. Entar the diseasa, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or raspiratory arrast, shock, or heert failure. Lisf only ona causa on aach lina.

Approximata Interval Between Onsef and Death

Immediata Causa (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequance of):

Sequantially list conditions, if any, laading to immadiata cause. Entar Underlying Cause (Disease or Injury that initiated events rasulting in death) Last

b.

Dua to (or as a consequanca of):

c.

Dua to (or as a consequanca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause givan in Part I.

23b. Did tobacco uaa contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yas 2 [ ] No

25. Was casa referred to medical examinar? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only ona)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Homa 5 [ ] Rasidance 6 [ ] Othar *(Specify)*

27. Mannar of Death: 1 [X] Natural 2 [ ] Accidant 3 [ ] Sulcide 4 [ ] Homicida 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Dascribe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifier *(Check only one)*: 1 [X] **Certifying Physician:** To tha best of my knowledga, deeth occurred at the time, date end place, and dua to the cause(s) and menner es steted. 2 [ ] **Medical Examiner:** On tha basis of axamination end/or investigetion, in my opinion, deeth occurred at tha tima, data end placa, and due to the cause(s) and mennar stated.

29b. Signatura and titla of certifiar: P. Ogbogu MD

29c. Licanse number: P14279

29d. Data signed *(Month, Day, Year)*: March 24, 2001

30. Name and addrass of parson who completed causa of daath (Item 23a) (Type, Print): P. Ogbogu, Sinai Hospital, 2401 W. Belvedere, Baltimore, MD

**State Registrar**

31. Data filed *(Month, Day, Year)*: MAR 2 6 2001

32. Registrar's Signatura: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Donald, George

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Amended Item#25 per VerbAl G793 3/26/2001 EW

# Certificate of Death

Reg. No. 2001 09040

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|---|---|
| Marie | E. | Fenhagen | March 18, 2001 | 10:00 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 5304 Greenhill Avenue | Baltimore | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-01-2837 | 1☐ M 2☒ F | 88 Yrs. | | | November 10, 1912 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | N/A | Baltimore | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 5304 Greenhill Avenue | 21206 | USA |

| 11. Meritel Stetus | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) | 14. Rece - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Merried 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Yeer or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementery/Secondary (0-12) | College (1-4or 5+) | | |
| 8th Grade | N/A | Homemaker | Own Home |

| 17. Fether's Name (First, Middle, Last) | 18. Mother's Neme (First, Middle, Maiden Surname) |
|---|---|
| Konstantine Pietsch | Antoinette Unknown |

| 19a. Informent's Neme/Reletionship (Type, Print) | 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Virginia Lanasa Friend | 1436 Henry Street Baltimore Maryland 21230 |

| 20a. Method of Disposition | 20b. Piece of Disposition (Neme of cemetery, cremetory or other piece) | Dete | 20c. Location - City or Town, Stete |
|---|---|---|---|
| 1☒ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify) | Parkwood Cemetery | 3/22/01 | Baltimore Maryland |

| 21. Signeture of Funerel Service Licensee | 22. Neme end Address of Fecility |
|---|---|
| Christina L. Hilton ▶ Christina A Hilton | Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one ceuse on eech line.

| | | Approximete Intervel Between Onset and Death |
|---|---|---|
| Immediete Causa (Finel disease or condition resulting in death) | a. CARCINOMA OF BREAST | 5y. |
| | Due to (or es a consequenca of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in death) Last | b. | |
| | Due to (or as a consequenca of): | |
| | c. | |
| | Due to (or es a consequenca of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☑ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☒ Yes 2☐ No | Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA | Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify) |

| 27. Menner of Death | 28a. Dete of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |
| | 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street end Number or Rural Route Number, City or Town, State) |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete and place, end due to the ceuse(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete and piece, end due to the ceuse(s) and manner stated.

| 29b. Signeture and title of certifier | 29c. License number | 29d. Dete signed (Month, Day, Year) |
|---|---|---|
| ▶ | D08340 | 3/19/01 |

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

Luis E Rivera- Ramirez 5714 Harford RD Balto.Md 21214

**State Registrar**

| 31. Dete filed (Month, Day, Year) | 32. Registrar's Signeture |
|---|---|
| MAR 2 6 2001 | ▶ Geneva G Sparks |

DHMH 16 Rev 6/95

ORIGINAL

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

#25
30

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09041

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Andrew Faulkner

2. Date of Death: Month March, Day 20, Year 2001

3. Time of Death: 8:25a.m.

4a. Facility Name (If not institution, give street and number): Joseph Ritchie Hospice

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 225-26-5740

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): Jan.10,1925

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 2933 Forest Glen Road

10f. Zip Code: 21216

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Service Technician

16b. Kind of Business/Industry: Baltimore Gas and Electric

17. Father's Name (First, Middle, Last): Andrew Faulkner

18. Mother's Name (First, Middle, Maiden Surname): Mary Garst

19a. Informant's Name/Relationship (Type, Print): Michael Faulkner-Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7930 Galloping Circle Balto. MD 21244

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Arbutus Mem. Pk. Cem. Date: 02/27

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Barry L. Nutter

22. Name and Address of Facility: Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy. Balto. Md 21216

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or haart tailura. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death): a. METASTATIC PROSTATE CANCER — 3 MONTHS

Due to (or es e consequence of):

Sequentially list conditions, it any, leading to immediete ceuse. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last:

b.

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of ceuse of death? 1 [ ] Yes 2 [ ] No

25. Was cese retarred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) HOSPICE

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) and menner as stated. 2 [ ] **Medical Examiner**: On the basis of examinetion end/or investigation, in my opinion, daath occurred et the time, date end piece, and due to the cause(s) end menner stated.

29b. Signature and title of certifier: I. A. SHALABY / PHYSICIAN

29c. License number: D0055532

29d. Dete signed (Month, Day, Year): 03/20/2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): ISMAIL A. SHALABY, M.D., Ph.D. 6569 N. CHARLES ST, TOWSON, MD 21204

**State Registrar**

31. Dete filed (Month, Day, Year): MAR 2 6 2001

32. Registrar's Signeture: Barbara G Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

3-20-01 8:35 AM

Andrew Faulkner

WB

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 09042

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Mary Genevieve Furlong

2. Date of Death: Month MARCH Day 23 Year 2001

3. Time of Death: 19:36 M

4a. Facility Name (If not institution, give street and number): Saint Agnes Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: n/a

**Funeral Director**

5. Social Security Number: 214-20-1372

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 13, 1923

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 601 Maiden Choice Lane

10f. Zip Code: 21228

10g. Citizen of What Country? United States

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): bookkeeper

16b. Kind of Business/Industry: dry cleaning

17. Father's Name (First, Middle, Last): William Victor Furlong

18. Mother's Name (First, Middle, Maiden Surname): Catherine B. Sturgeon

19a. Informant's Name/Relationship (Type, Print): Clotilde Furlong - sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 601 Maiden Choice Lane, Catonsville, Maryland 21228

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): New Cathedral Cemetery

Date: 3/27/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Ann Y. Zink

22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 21229

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis — 6 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

congestive heart failure

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha ceuse(s) and manner stated.

29b. Signature and title of certifier: ▶ Leila Kump, M.D.

29c. License number: P 14444

29d. Date signed (Month, Day, Year): March 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LEILA KUMP 900 S Caton Ave, Baltimore, MD 21229

**State Registrar**

31. Date filed (Month, Day, Year): MAR 26 2001

32. Registrar's Signature: ▶ Linda S. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME Genevieve Furlong

Division of Vital Records, P.O. Box 68760,

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09043

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Mildred Grazuties

2. Date of Death — Month: MARCH Day: 20 Year: 2001

3. Time of Death: 1:17 P.M.

4a. Facility Name (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL CENTER

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 219-26-6406

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 62 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 21, 1938

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 8366 Tapu Court

10f. Zip Code: 21236

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Dispatcher

16b. Kind of Business/Industry: Private Co.

17. Father's Name (First, Middle, Last): Anthony Plona

18. Mother's Name (First, Middle, Maiden Surname): Bertha Borkowski

19a. Informant's Name/Reletionship (Type, Print): Gary Grazuties, Sr.- Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8366 Tapu Court Baltimore, Maryland 21236

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): St. Stanislaus Cemetery

Date: 3/26/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Heather Cain

22. Name and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Cardiovascular Disease — 25 years

Due to (or as a consequence of):

b. Diabetes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D. deputy

29c. License number: D18667

29d. Date signed (Month, Day, Year): March 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Philip Militello Shock Trauma 225 Greene St. Baltimore, Md 21201

**State Registrar**

31. Date filed (Month, Day, Year): MAR 26 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Mildred Grazuties

01-1493-510
mnmr
Micheal Greene

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

2001 09044 Reg. No.

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Michael E. Greene
2. Date of Death Month Day Year: March 16, 2001
3. Time of Death: 2119 M

4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 216-52-9521
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 52 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year):
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1203 N Decker
10f. Zip Code: 21213
10g. Citizen of What Country? USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1969 to 1972
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Maintenance
16b. Kind of Business/Industry: Private Ind.

17. Father's Name (First, Middle, Last): Ralph Pitt
18. Mother's Name (First, Middle, Maiden Surname): Dorothy Greene

19a. Informant's Name/Relationship (Type, Print): Adrienne Greene (daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4404 Chalet Ct. Apt B1 # Baltimore MD

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Northern Va, Crem. | Date: 3/26/01
20c. Location - City or Town, State: Arlington, Virginia

21. Signature of Funeral Service Licensee: Leander M Coles
22. Name and Address of Facility: TRI-STATE F/S 108 W. North Ave, Baltimore, MD.

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Atherosclerotic Cardiovascular Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Theodore M. King MD
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): March 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE M. King 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): MAR 26 2001
32. Registrar's Signature: G Sparks

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification; To Be Completed by Physician/Medical Examiner**

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09045

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ELEANOR ANITA HIMBRY

2. Date of Death: Month MARCH Day 15 Year 2001

3. Time of Death: 1:12 PM

4a. Facility Name (If not institution, give street and number): SINAI HOSPITAL OF Baltimore

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 218 466 227

8. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 54 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JAN. 27, 1947

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD.

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☑ Yes 2☐ No

10e. Street and Number: 1516 EUTAW PLACE APT. 102

10f. Zip Code: 21217

10g. Citizen of What Country? U.S. OF A.

11. Meritat Status: 1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☐ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): UNKNOWN

College (1-4or 5+): UNKNOWN

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CORDINATOR

16b. Kind of Business/Industry: SKILL CENTER

17. Father's Name (First, Middle, Last): WILLIAM LOUIS BOYER

18. Mother's Name (First, Middle, Maiden Surname): BEATRICE SIMMONS

19e. Informant's Name/Relationship (Type, Print): VERNATTA HIMBRY (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4267 LABYRINTH RD. BALTO., MD. 21215

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): ARBUTUS MEM. PARK Date 3/20/2001

20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: LEWIS T. GWYNN ▶ Lewis T. Gwynn

22. Name and Address of Facility: LEWIS T. GWYNN FUNERAL HOME 21215-6393 4517 PARK HEIGHTS AVENUE BALTO., MD.

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. metastatic Breast CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date end placa, end due to the cause(s) and menner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Physician

29c. License number: D 00 54558

29d. Date signed (Month, Day, Year): March 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FREDERICK BURKE, JR, MD. 2401 W. Belvedere Ave Balto md. 21215

**State Registrar**

31. Date filed (Month, Day, Year): MAR 2 6 2001

32. Registrar's Signature: ▶ Sandra G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**To Be Completed by Funeral Director**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

PT: Known AS Himbry, Eleanor

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

2001 09046 Reg. No.

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| John Francis Hoffen, Sr. | March 22 2001 | 1030 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Mariner Health of Catonsville | Catonsville | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 140-16-6700 | 1 [X] M 2 [ ] F | 76 Yrs. | | | 03/28/1924 | New Jersey |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Baltimore | Catonsville | 1 [ ] Yes 2 [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 203 Brookside Drive | 21228 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II | 1 [ ] Yes 2 [X] No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 6+ | Agent/Manager of Human Resource | NSA |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Harry Hoffen | Mary Tobin |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Eileen Hoffen/Wife | 203 Brookside Drive Baltimore, MD 21228 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Baltimore National | 03/26/2001 | Baltimore, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| [signature] | Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Ave. Baltimore, MD 21228 |

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complications that caused tha death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heert failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Alzheimers Disease

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequenca of):
d. Due to (or as a consequenca of):

| IF FEMALE: 23b. Wes decedent pregnant in tha past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivary Month / Day / Year |
|---|---|---|
| 1 [ ] Yes 2 [ ] No 9 [ ] Unknown | 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 [ ] Yes 2 [X] No | 1 [ ] Yes 2 [ ] No |

| 25. Wes case referred to medical examiner? | 28. Place of Death (Check only one) |
|---|---|
| 1 [ ] Yes 2 [X] No | Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined | N/A | M | 1 [ ] Yes 2 [ ] No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete and place, end due to the ceuse(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] MD | D15872 | March 25, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Harold Bub 25 Main Street Reisterstown Maryland 21136

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 26 2001 | [signature] Geneva G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

2001 09047 Reg. No.

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Kathleen H. Hilbert | March 22 2001 | 10:25P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Augsburg Lutheran Nursing Home | Baltimore | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-09-6811 | 1☐M 2☒F | 84 Yrs. | | | 11/16/1916 | MD |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Baltimore | Windsor Mill | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 8307 Dogwood Rd. | 21244 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 10 | | Bank Teller | Banking |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Leland Spencer | Eleanora Klages |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Diane Day - Daughter | 718 Franklin Ave. Westminster, MD 21157 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Baltimore/Washington | 3/25/2001 | Laurel, MD |

21. Signature of Funeral Service Licensee: Bernard Balawski

22. Name and Address of Facility: Witzke Funeral Home of 21228 Catonsville 1630 Edmonson Ave. Catonsville, MD

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Cryptogenic cirrhosis | years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☒Nursing Home 5☐Residence 8☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| | D37573 | March 24, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jeff Tibbell MD 25 Main Str. Reisterstown MD 21136

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 2 6 2001 | Geneva G Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09048

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): MARY ELIZABETH HOUPT
2. Date of Death (Month, Day, Year): MARCH 17, 2001
3. Time of Death: 3:25 PM
4a. Facility Name (If not institution, give street and number): JULIA MANOR NURSING HOME
4b. City, Town, or Location of Death: HAGERSTOWN
4c. County of Death: WASHINGTON

**Funeral Director**

5. Social Security Number: 214-09-6870
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov 30, 1915
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 333 Mill Street
10f. Zip Code: 21740
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): housewife
16b. Kind of Business/Industry: none

17. Father's Name (First, Middle, Last): Christian Ebersole
18. Mother's Name (First, Middle, Maiden Surname): Kathern Lydia Wedding

19a. Informant's Name/Relationship (Type, Print): Nancy Haney/daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 502 C Lynnhaven Drive Hagerstown, MD 21742

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place):
Date:
20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ISCHEMIC CARDIOMYOPATHY — 5 years
Due to (or as a consequence of):
b. Atherosclerotic Coronary Artery Disease
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Metastatic Breast Cancer

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Dino J. DeGregorio
29c. License number: D26523
29d. Date signed (Month, Day, Year): March 19, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DINO J. DEGREGORIS MD 11110 MEDICAL CAMPUS ROAD HAGERSTOWN MARYLAND 21742

**State Registrar**

31. Date filed (Month, Day, Year): MAR 26 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

2001 09049
Reg. No.

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| George Horner | 03 / 22, 2001 | 1123 4M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| University of Maryland Medical System | Baltimore | Baltimore City |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-34-6085 | 1☒M 2☐F | 62 Yrs. | | | Jan. 15, 1939 | West Virginia |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Anne Arundel | Pasadena | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 7872 A. W. Riverside Drive | 21122-3824 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 11 | 0 | Driver | Transportation |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| George Bruce Horner | Nellie Mae Butts |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Darlene Horner / Wife | 7872 A. West Riverside Drive, Pasadena, Maryland 21122 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Bayview Crematory | 3/23/2001 | Baltimore, Maryland |

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. SEPSIS | 4 DAYS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. PNEUMONIA | 4 DAYS |
| | Due to (or as a consequence of): c. EMPHYSEMA | YEARS |
| | Due to (or as a consequence of): d. Coronary Artery Disease | YEARS |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

| 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|
| 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] RESIDENT | 08416 | 03/22/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MITCHELL A. CAHAN, MD 22 S. GREENE ST. BALTIMORE, MD 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 26 2001 | ▶ [signature] |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #12 PER F.H. G793 3-26-01 WR.

## Certificate of Death

Reg. No. 2001 09050

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| JESSIE | N | JOHNSON | MARCH 19 2001 | 11 50 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| BON SECOURS HOSPITAL | BALTIMORE | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 224-18-8216 | 1☑ M 2☐ F | 79 Yrs. | | | April 13, 1921 | Louisiana |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | N/A | Baltimore | 1☑ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 10 N. Rockglen Rd. | 21229 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☑ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced | 1☒ Yes 2☑ No If Yes, Give Year or Dates: | 1☐ Yes 2☑ No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | Collector | Oil Co. |
| 10th | | | |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| unk. | Viola Johnson |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Evelyn Mewborn · Stepdaughter | 945 As Balto., MD. 21216 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Baltimore Nat. Cemetery | 3-26-01 | Baltimore, MD. |

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility: Gary F. March Funeral Home, P.A. 270 Fredhilton Pass, Balto., MD. 21229

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. END STAGE RENAL DISEASE | |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

GASTRO INTESTINAL BLEED

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☑ No | 1☐ Yes 2☑ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☑ No | Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29e. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ T Kornilios md | D30272 | 3/19/2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
THOMAS S. MILLER BON SECOURS HOSPITAL BALTIMORE, MD.

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 26 2001 | ▶ [signature] G. Sparks |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28d-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09051

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): LESLIE JENKINS
2. Date of Death: Month MARCH Day 20 Year 2001
3. Time of Death: 11:35 PM
4a. Facility Name (If not institution, give street and number): HARBOR HOSPITAL CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: NA

**Funeral Director**

5. Social Security Number: 213-18-1345
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 90 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUG. 4, 1910
9. Birthplace (State or Foreign Country): VA

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 178 W. HAMBURG STREET
10f. Zip Code: 21230
10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1945-1947
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: AFRICAN AMERICAN

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6th; College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CRANE OPERATOR
16b. Kind of Business/Industry: BETH STEEL

17. Father's Name (First, Middle, Last): TOM JENKINS
18. Mother's Name (First, Middle, Maiden Surname): BERTHA WILLIAMS

19a. Informant's Name/Relationship (Type, Print): CORA JENKINS (DAUGHTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 174 W. HAMBURG STREET BALTIMORE, MD 21230

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): GARRISON FOREST VET. CEM
Date: 3/29/01
20c. Location - City or Town, State: OWINGS MILLS, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: WYLIE FUNERAL HOME PA 638 N. GILMOR STREET BALTIMORE, MD 21217

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE MYOCARDIAL INFARCTION
Due to (or as a consequence of):
HASCVD

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown
TOBACCO USE

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MICHELE DICENOSKIE DO
29c. License number: #D0055706
29d. Date signed (Month, Day, Year): MARCH 20, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MICHELE DICENOSKIE DO HARBOR HOSPITAL CENTER 3001 S. HANOVER ST BALTIMORE MD 21225

**State Registrar**

31. Date filed (Month, Day, Year): MAR 2 6 2001
32. Registrar's Signature: [signature]

ORIGINAL

DHMH 16 Rev 6/95

---

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09052

Elvie Johnson

Baltimore, Maryland 21215-0020

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ELVIE E. JOHNSON

2. Date of Death: Month March, Day 22, Year 2001

3. Time of Death: 13:30 PM

4a. Facility Name (If not institution, give street and number): Deaton Specialty Hospital and Home

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

**Funeral Director**

5. Social Security Number: 072-20-9196

6. Sex: 1☐ M 2☑ F

7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): OCT. 13, 1925

9. Birthplace (State or Foreign Country): SC

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: ☒ Yes 2☐ No

10e. Street and Number: 2555 FRANCIS STREET

10f. Zip Code: 21217

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: AFRICAN AMERICAN

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+): NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MODEL

16b. Kind of Business/Industry: FASHION HOUSE

17. Father's Name (First, Middle, Last): JOSEPH ORR

16. Mother's Name (First, Middle, Maiden Surname): BRIDER ORR

19a. Informant's Name/Relationship (Type, Print): JAMES B. JOHNSON (HUSBAND)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2555 FRANCIS STREET BALTIMORE, MD 21217

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): METRO CREMATORY

Date: 3/23/01

20c. Location - City or Town, State: CATONSVILLE, MD

21. Signature of Funeral Service Licensee ▶

22. Name and Address of Facility: WYLIE FUNERAL HOME PA 638 N. GILMOR STREET BALTIMORE, MD 21217

**Physician /Medical Examiner**

23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Severe chronic obstructive lung disease — yrs.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

**Medical Certification: To Be Completed by Physician/Medical Examiner**

25. Was case referred to medical examiner? 1☑ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶ C Mehta MD

29c. License number: D34974

29d. Date signed (Month, Day, Year): March, 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHARU MEHTA, MD 8775 cloudleap ct # 224, columbia, MD 21045

**State Registrar**

31. Date filed (Month, Day, Year): MAR 26 2001

32. Registrar's Signature ▶ Lenore D Sparks

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 09053

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| Edward | Johnson | Jr. | Mar. 16, 2001 | 19:10 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Univ. of Maryland Medical System | Baltimore | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-68-4138 | 1☒M 2☐F | 44 Yrs. | | | 5/30/56 | Baltimore, Md. |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md. | | Baltimore | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 836 Harford Ct. | 21208 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Unknown | Unknown |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Joseph Johnson Sr. | Annie Wynn |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Catherine Wright | 1110 Warwick Ave, Baltimore, Maryland 21217 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Mt. Zion Cem. | 3/21/01 | Lansdowne, Md. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Lloyd M. Estep | Estep Brothers Funeral Ser. P.A. 1300 Eutaw Pl, Baltimore, Md. 21217 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Sepsis | 1/7/01 |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. Gastrointestinal Bleed | 1/7/01 |
| | Due to (or as a consequence of): c. Adult Respiratory Distress Syndrome | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Human Immunodeficiency Virus Positive

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☒Yes 2☐No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ | P14699 | 3/16/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GIANAKOS 22 S. Greene St., Baltimore, Md 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 2 6 2001 | ▶ D Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

2001 09054
Reg. No.

Kauffman, Jean March 23, 2001 10:30 A.M.

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 26a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Physician /Medical Examiner**

**Funeral Director**

**To Be Completed by Funeral Director**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|
| Eugenia Jean Elizabeth Kauffman | March 23, 2001 | 10:30 A. M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Gilchrist Center | Towson | Baltimore Co. |

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-14-5806 | 1☐M 2☒F | 84 Yrs. | | | November 04, 1916 | Baltimore, Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore Co. | Towson | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1000 East Joppa Road | 21286 | United States of America |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 02 | Clerical | Baltimore Co. Government |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Burgess Reid Lennan | May M. Whitley |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mrs. Janet Brooks(nee Kauffman)Christensen (Daughter) | 2908 Mayfield Ave. Baltimore, Maryland 21244 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Sherwood Epis.Ch.Cemetery | 3/26/2001 | Cockeysville, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Jeffrey L. Gair, Sr. Jeffrey L. Gair, Sr. | Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Lung cancer | 4 months |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery (Month, Day, Year) |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☒Other (Specify) Hospice |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ W. Anthony Riley, MD | D25205 | March 23, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
W. A. Riley GBMC 6701 N. Charles St. Balto. Md 21204

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 26 2001 | ▶ Geneva G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

2001 09055
Reg. No.

Joseph Kues 21 MAR 24 2001 4 45 Am

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Joseph Clifton Kues
2. Date of Death Month/Day/Year: March 21 2001
3. Time of Death: 4:45 AM
4a. Facility Name (If not institution, give street and number): Joseph Richey Hospice
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

**Funeral Director**

5. Social Security Number: 216-24-9888
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 6 1931
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: W. Va.
10b. County: Monongalia
10c. City, Town or Location: Morgantown
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 707-11 Fairmont Road
10f. Zip Code: 26501
10g. Citizen of What Country?: U.S. of America

11. Meritel Stetus: 1☐ Never Married 2☐ Merried 3☐ Widowed 4☒ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Rece - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 6 | College (1-4or 5+): NA
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Asbestos worker
16b. Kind of Business/Industry: Pipe Covering

17. Father's Neme (First, Middle, Last): Raymond Kues
18. Mother's Name (First, Middle, Maiden Surneme): Clara Dasch

19a. Interment's Name/Reletionship (Type, Print): Sharon Walker (Daughter)
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 116 Hastings Court Abingdon, Maryland 21009

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Sacred Heart of Jesus
Dete: March 23,2001
20c. Location - City or Town, Stete: Dundalk, Maryland

21. Signeture of Fenerel Service Licensee: ▶ Mark A. Chojnacki
22. Name and Address of Fecility: W. Dabrowski-Chojnacki F.H.'s P.A. 1005 Dundalk Ave. Balto., Md. 21224

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart teilure. List only one cause on eech line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediete Causa (Final disease or condition resulting in death) | a. Metastatic Small cell lung cancer | 5 months |
| | Due to (or es a consequenca of): | |
| Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or Injury thet intieted events resulting in death) Last | b. | |
| | Due to (or es e consequenca of): | |
| | c. | |
| | Due to (or es a consequenca of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

prostate cancer
carotid vascular disease
inferior vena caval thrombosis

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No
26. Piece of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) hospice
27. Menner of Death: 1☒ Netural 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, term, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ Certifying Phyaician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) and menner as stated. 2☐ Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signeture and title of certifier: ▶ Brent Macdonald, MD PHYSICIAN
29c. License number: D47105
29d. Dete signed (Month, Day, Year): 3/21/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Brent Macdonald, MD 2400 KIRK Ave. Balt, MD 21218

**State Registrar**

31. Date filed (Month, Day, Year): MAR 26 2001
32. Registrer's Signeture: ▶ Jessica B. Sparks

ORIGINAL

DHMH 16 Rev 6/95

---

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09056

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Robert J. Kuser

2. Date of Death Month / Day / Year: March 20 2001

3. Time of Death: 6:40 P.m.

4a. Facility Name *(If not institution, give street and number)*: North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 214-24-5685

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(in yrs. last birthday)*: 74 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 10, 1927

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Gambrills

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 2114 Autumn Haze Court

10f. Zip Code: 21054

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1 ☒ Yes 2 ☐ No If Yes, Give Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1 ☐ Yas 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highast grada completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Food Service Director

16b. Kind of Business/Industry: Healthcare

17. Father's Name *(First, Middle, Last)*: Edwin A. Kuser

18. Mother's Neme *(First, Middle, Meiden Surname)*: Gertrude Dolan

19a. Informant's Name/Relationship *(Type, Print)*: Viola M. Kuser / wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2114 Autumn Haze Court, Gambrills, Maryland 21054

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other *(Specify)* entombment

20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Meadowridge Mem. Park

Date: 3/24/01

20c. Location - City or Town, State: Elkridge, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only ona cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in deeth) Last

b. PNEUMONIA

Due to (or as a consequenca of):

c. END STAGE RENAL FAILURE

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was casa referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death *(Check only one)*: Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other *(Specify)*

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☑ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD

29c. Licensa number: D43977

29d. Date signed *(Month, Day, Year)*: March 20 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Myron Olesinski. 301 Hospital Drive, Glen Burnie, MD. 21061.

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 26 2001

32. Registrar's Signature: ▶ [signature] D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

Kuser, Robert J.

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09057

AMEND ITEM: #30 PER F.H. G793 3-26-01 WR.

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): MELVIN B. LOCKLEAR, SR.

2. Date of Death: Month March Day 19 Year 2001

3. Time of Death: 11:23 PM

4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 220-36-8568

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 60 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): DECEMBER 27, 1940

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD

10b. County:

10c. City, Town or Location: ESSEX

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 1005 THOMPSON BLVD

10f. Zip Code: 21221

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 6 YRS

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SYSTEMS ENGINEER

16b. Kind of Business/Industry: TECHNOLOGY

17. Father's Name (First, Middle, Last): CHARLES U. LOCKLEAR, SR

18. Mother's Name (First, Middle, Maiden Surname): DELORES BENNETT

19a. Informant's Name/Relationship (Type, Print): C. VERNON LOCKLEAR

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12300 REMMINGTON DR. SILVER SPRINGS, MD 20902

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): ST ALPHONSUS CEMETERY

Date: 3/24/01

20c. Location - City or Town, State: WOODSTOCK, MD

21. Signature of Funeral Service Licensee: Vaughn C. Greene

22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL SERVS 4905 YORK Rd. BALTO, MD 21212

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Sudden Death - Cardiopulmonary Arrest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus, Sleep Apnea, Recent Heart valve Replacement

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Roland Vargas MD

29c. License number: D17150

29d. Date signed (Month, Day, Year): 3/23/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROLANDO VARGAS JR. 19 HUNT VALLEY VIEW TER. PHOENIX MD 2131

**State Registrar**

31. Date filed (Month, Day, Year): MAR 26 2001

32. Registrar's Signature: ▶ Steven D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

Locklear Melvin

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 09058

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Eleanor Lindinger | MARCH 22 2001 | 527 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| ST AGNES HOSPITAL | BALTIMORE | n/a |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-14-8217 | 1☐M 2☒F | 88 Yrs. | | | April 17, 1912 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Baltimore | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 730 Warwick Road | 21229 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 10 | | Baker | Bakery |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Martin Molitor | Anna Zeitvogel |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Joan Branamen / friend | 728 Warwick Road, Baltimore, Maryland 21229 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Loudon Park Cemetery | 3/24/01 | Baltimore, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Ann F. Zink | Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. SEPSIS | 1 week. |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☒No |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Shirin Ahmad RESIDENT PHYSICIAN | P144138 | MARCH 22, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SHIRIN AHMAD 900 CATON AVE BALTIMORE, MARYLAND 21229

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 26 2001 | ▶ Shirin G. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME ELEANOR LINDINGER
42
10

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

2001 09059
Reg. No.

McCoy, Reuben 7:45a.m. March 23, 2001

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Dr. Reuben Christopher McCoy, Jr. | March 23, 2001 | 7:45 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Hospice Of Baltimore, Gilchrist Cntr. | Towson | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 228-50-7956 | 1☒M 2☐F | 60 Yrs. | | | 01/11/1941 | VA |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Baltimore | Timonium | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 45 Blondell Court | 21093 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: American Indian |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 5+ | Doctor | Medical |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Reuben Christopher McCoy, Sr. | Lillie White Davis |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Vivian Scott McCoy/wife | 45 Blondell Court Timonium, Maryland 21093 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☒Other (Specify) Entombment | Fort Hill Mem. Park | 03/27/2001 | Lynchburg, VA |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Stephen D. Coster M01122 | Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Colon cancer — 14 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown | 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | 23d. Date of delivery Month Day Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Lymphoma

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☒No 3☐Probably 4☐Unknown | 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 8☒Other (Specify) Hospice |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| W. Anthony Riley, MD | D25025 | March 23, 2001 |

30. Name and address of person who completed cause of death (Item 29a) (Type, Print)
W. A. Riley OBMC 6701 N. Charles St. Balto. Md 2120x

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 26 2001 | Geneva G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09060

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): William Miller, Jr.
2. Date of Death (Month, Day, Year): March 22, 2001
3. Time of Death: 10:00 A.M.
4a. Facility Name (If not institution, give street and number): 67 Rol-Park Trailer Village
4b. City, Town, or Location of Death: Millersville
4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 215-24-7804
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 72 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 28, 1928
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Millersville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 67 Rol-Park Trailer Village
10f. Zip Code: 21108
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: '51-'52
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter
16b. Kind of Business/Industry: Railroad

17. Father's Name (First, Middle, Last): William Miller, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Helen Bears

19a. Informant's Name/Relationship (Type, Print): Clara M. Miller / Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 67 Rol-Park Trailer Village, Millersville, MD 21108

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Crownsville MD Vet. Cem.
Date: Mar. 26 2001
20c. Location - City or Town, State: Crownsville, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, MD 21061

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) e. | ACUTE CEREBROVASCULAR ACCIDENT | 5 HOURS |
| Due to (or as a consequence of): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. | GENERALIZED ARTERIOSCLEROSIS | 20 YEARS |
| Due to (or as a consequence of): | | |
| c. | | |
| Due to (or as a consequence of): | | |
| d. | | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE
HYPERTENSION
DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D
29c. License number: D-22609
29d. Date signed (Month, Day, Year): March 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ruben Reider, M.D., 7445A Furnace Branch Rd., Glen Burnie, Maryland 21060

**State Registrar**

31. Date Filed (Month, Day, Year): MAR 2 6 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09061

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Herbert Allen Mezger

2. Date of Death — Month: March; Day: 22; Year: 2001

3. Time of Death: 3:20 pm

4a. Facility Name *(If not institution, give street and number)*: Charlestown Care Center

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 213-05-3235

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 86 Yrs.

If Under 1 Year — Months: ; Days:

If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth *(Month, Day, Year)*: Oct. 13, 1914

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 717 Maiden Choice Lane St. Charles Apt. 301

10f. Zip Code: 21228

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: WW 11

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): ; College (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Attorney

16b. Kind of Business/Industry: Private Law Practice

17. Father's Name *(First, Middle, Last)*: Irving Herbert Mezger

18. Mother's Name *(First, Middle, Maiden Surname)*: Ethel Hillary Bell

19a. Informant's Name/Relationship *(Type, Print)*: Jeanne Mezger- Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 717 Maiden Choice Lane-Apt.301 St. Charles Catonsville, Md.21228

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Meadowridge Memorial Park

Date: 03/26/2001

20c. Location - City or Town, State: Elkridge, MD.21075

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Witzke Funeral Home, Inc. 1630 Edmondson Avenue, Catonsville, MD.21228

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. End stage congestive heart failure — YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Andres Salazar

29c. License number: D51051

29d. Date signed *(Month, Day, Year)*: March 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Andres Salazar, 711 Maiden choice Lane, Catonsville, MD 21228

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Name: Herbert Mezger

8

6

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 26 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09062

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Robert Wiley Marr Jr.
2. Data of Death Month: 3- Day: 1- Year: 01
3. Time of Death: 01:43 AM
4a. Facility Name (If not institution, give street and number): 578 Melissa Court
4b. City, Town, or Location of Death: Arnold
4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 254-28-2853
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 77 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): 10-14-1923
9. Birthplace (State or Foreign Country): Ashville N.C

Usual Residence of Decedent

10a. State: Md.
10b. County: Anne Arundel
10c. City, Town or Location: Arnold
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 578 Melissa Court
10f. Zip Code: 21012
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Yaer or Datas: 1942-1958
13. Wes Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12; College (1-4or 5+): 4
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): G.T.E. Marketing Mgr.
16b. Kind of Business/Industry: Communications

17. Father's Neme (First, Middle, Last): Robert Wiley Marr Sr.
18. Mother's Name (First, Middle, Maiden Surneme): Laura Lucille Wells - Marr

19a. Informent's Name/Reletionship (Type, Print): Sylvia Mundy Marr Wife
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 578 Melisa Court, Arnold Md. 21012

20a. Method of Disposition: 1 ☒ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stata 4 ☐ Donetion 5 ☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Graham Cemetery
Dete: 3-6-01
20c. Location - City or Town, Stete: Orange Va.

21. Signeture of Funerel Service Licensee: Joseph W Preddy CC0204
22. Nema and Address of Facility: Preddy Funeral Home, Bx 321 Orange Va. 22960

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications thet ceused tha death. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

| | | Approximete Interval Between Onset and Deeth |
|---|---|---|
| Immedlete Ceuse (Finel diseese or condition resulting in deeth) e. | Metastatic Esophageal Cancer | 5 months |
| Due to (or es e consequence of): | | |
| Sequentielly list conditions, if any, leading to immediete ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in daath) Last b. | | |
| Due to (or es e consequence of): | | |
| c. | | |
| Due to (or es e consequence of): | | |
| d. | | |

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Wes en autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Wes cese referred to medicel examiner? 1 ☐ Yes 2 ☒ No

28. Piece of Death (Check only one): Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Daughter's Home

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2 ☐ **Medical Examinsr**: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, dete and piece, and due to the cause(s) and menner steted.

29b. Signetura and title of certifier: Elizabeth Heath medical oncology
29c. Licansa number: D0050753
29d. Date signed (Month, Day, Year): March 26, 2001

30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print): 1650 Orleans Street, G-89, Baltimore, MD 21231

**State Registrar**

31. Date filed (Month, Dey, Yeer): MAR 26 2001
32. Registrer's Signeture: Barbara G. Sparks

DHMH 16 Rev 6/95

---

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

01-1467-510

mnmr AMND ITM#9&20a

James Mackey AMND ITM#4c,12,16a&b,19a&b,20b&c PR. F,H. G794 4-13-01 JAB

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

2001 09063 Reg. No.

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| JAMES MACKEY | March 15, 2001 | 2314 pM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Maryland General Hospital | Baltimore | ~~N/A~~ |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-36-2641 | 1[X] M 2[ ] F | 60 Yrs. | | | Jan 17, 1941 | ~~unk~~ WEST V.A. |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | | Baltimore | 1[X] Yes 2[ ] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1414 Retreat Street | 21217 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| unk 1[ ] Never Married 2[ ] Married 3[ ] Widowed 4[ ] Divorced | 1[ ] Yes 2[XX] No ~~unk~~ If Yes, Give Year or Dates: | 1[ ] Yes 2[X] No Specify: | Specify: black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| ~~unk~~ 11th | unk | JANATORIAL | MARS SUPERMARKET |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| unk | unk |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| ~~Maryland General Hospital~~ ELIZABETH TYLER | ~~827 Linden Ave Baltimore, MD 21201~~ 1732 E. LAFAYETTE AVE. BALTO. MD. 21213 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1[ ] Burial 2[X] Cremation 3[ ] Removal from State 4[ ] Donation 5[X] Other (Specify) ~~in state~~ | BAYVIEW CREMATORY | 4/12/01 | BALTO. MD. |

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: ~~State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201~~ MILLER METROPOLITAN CHAPEL P.C. 1639 N. BROADWAY

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Hypertensive Arteriosclerotic Cardiovascular Disease | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1[ ] Yes 2[ ] No 9[ ] Unknown | 1[ ] Live birth 2[ ] Fetal death 3[ ] Ectopic pregnancy 4[ ] Pregnant at time of death 5[ ] Other (specify) _____ 9[ ] Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1[ ] Yes 2[ ] No 3[ ] Probably 4[XX] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1[ ] Yes 2[XX] No | 1[ ] Yes 2[X] No |

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) | |
|---|---|---|
| 1[X] Yes 2[ ] No | Hospital: 1[ ] Inpatient 2[X] ER/Outpatient 3[ ] DOA | Other: 4[ ] Nursing Home 5[ ] Residence 8[ ] Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1[XX] Natural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined | | M | 1[ ] Yes 2[ ] No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)

1[ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2[X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha ceuse(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| J Pestaner, M.D. | O.C.M.E. | March 17, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph P. Pestaner M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 2 6 2001 | Geneva G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

Jacquelyn Millard
CJ
01-1606-005

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

061301 1-SS For State Registrar AMEND ITEM 23a, 27 per ME G796 3-26-01 WR. AMEND ITEM: #20B PER F.H. G793

State of Maryland / Department of Health and Mental Hygiene
*Certificate of Death*

2001 09064
Reg. No.

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| Jacquelyn | Gayle | Millard | March | 22 | 2001 | 11:45 A.M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 16 Salthill Court | Timonium | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 276-34-9612 | 1☐M 2☒F | 63 Yrs. | | | | | Nov 23, 1937 | Florida |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Timonium | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 16 Salthill Court | 21093 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementery/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 01 | Claims Consultant | Insurance |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Jack Millard | Nona Hinson |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Pat Bentrim/Sister | 6 Jocassee Court, Greenville, SC 29609 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Baltimore-Washington Crematory | 3/24/01 ~~3/31/01~~ | Laurel, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Bryant W. Clary | Lemmon Funeral Home 10 W. Padonia road, Timonium, MD 21093 |

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. BRONCHOPNEUMONIA | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as e consequence of): b. | |
| | Due to (or as a consequenca of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Data of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☒Yes 2☐No | 1☒Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☒Yes 2☐No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) Scene |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Stephen S. Radentz, M.D. | O.C.M.E. | March 23, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 26 2001 | Donna G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 09065

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): MICHAEL DANIEL ORLANDO
2. Date of Death (Month, Day, Year): MARCH 18 2001
3. Time of Death: 8:51 P M
4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

**Funeral Director**

5. Social Security Number: 183-18-2304
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 79 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Mar 16, 1922
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 30 North Place
10f. Zip Code: 21701
10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): +5
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): microbiologist
16b. Kind of Business/Industry: research

17. Father's Name (First, Middle, Last): Benianino Orlando
18. Mother's Name (First, Middle, Maiden Surname): Elizabetha Gubitosi

19a. Informant's Name/Relationship (Type, Print): Tomassina Orlando/spouse
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 30 North Place Frederick, MD 21701

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place):
Date:
20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. HYPOXEMIA — 24 HOURS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. ASPIRATION PNEUMONIA — 2 WEEKS
Due to (or as a consequence of):
c. MULTIPLE CEREBROVASCULAR ACCIDENTS — YEARS
Due to (or as a consequence of):
d. ATHEROSCLEROSIS of CORONARIES CAROTIDS — YEARS

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Liva birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown
23d. Data of delivery: Month Dey Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CARDIOMYOPATHY - HEART FAILURE
VALVULAR DISEASE OF THE HEART
ACUTE RENAL FAILURE

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
28. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year):
28b. Time of Injury: M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred:
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify):
28f. Location (Street and Number or Rural Route Number, City or Town, State):

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: D47556
29d. Date signed (Month, Day, Year): 3-18-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WILLIAM H. JOHNSON, MD, 172 THOMAS JOHNSON DRIVE, FREDERICK MD 21702

**State Registrar**

31. Date filed (Month, Day, Year): MAR 26 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

---

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

ADMEND ITEM: #5 REB F H G794 4-30-01 WR

1- For State Registrar

# State of Maryland / Department of Health and Mental Hygiene
## Certificate of Death

2001 09066 Reg. No.

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Edward Oberdalhoff, Sr.

2. Date of Death Month: March Day: 25 Year: 2001

3. Time of Death: 6:20 AM M

4a. Facility Name (If not institution, give street and number): 6012 Charles St.

4b. City, Town, or Location of Death: Catonsville Manor

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 220-05-9289 ~~220-05-9285~~

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 07/29/1919

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Catonsville Manor

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 6012 Charles St.

10f. Zip Code: 21207

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 4; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Maintenance

16b. Kind of Business/Industry: Post Office

17. Father's Name (First, Middle, Last): Edward Oberdalhoff

18. Mother's Name (First, Middle, Maiden Surname): Loena Adams

19a. Informant's Name/Relationship (Type, Print): Lillian E. Oberdalhoff/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6012 Charles St. Baltimore, MD 21207

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Woodlawn Cemetery

Date: 03/28/01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: ▶ Robert Wodach

22. Name and Address of Facility: Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Ave. Baltimore, MD 21228

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. AS CVD — Yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

Due to (or as a consequence of): b. HTN — Yrs.

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DM II

II A Hyperlipidemia

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No

28. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ B Turakhia M.D. Attending MD

29c. License number: D36942

29d. Date signed (Month, Day, Year): March 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): B TURAKHIA MD. 1009, Frederick Rd. Baltimore, MD 21228

**State Registrar**

31. Date filed (Month, Day, Year): MAR 2 6 2001

32. Registrar's Signature: ▶ Genevieve L. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

2001 09067 Reg. No.

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): LESTER B PUFFINBERGER, JR
2. Date of Death Month: 3 Day: 15 Year: 01
3. Time of Death: 635 PM
4a. Facility Name (If not institution, give street and number): UNIVERSITY OF MARYLAND
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE CITY

**Funeral Director**

5. Social Security Number: 229-80-5616
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 46 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JULY 14, 1954
9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: GLEN BURNIE
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 200 BERTRAM CIRCLE
10f. Zip Code: 21060
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DELIVERY PERSON
16b. Kind of Business/Industry: APPLIANCE

17. Father's Name (First, Middle, Last): LESTER B. PUFFINBERGER, SR.
18. Mother's Name (First, Middle, Maiden Surname): LAURIE E. JENKINS

19a. Informant's Name/Relationship (Type, Print): DAVID PUFFINBERGER SR./BROTHER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 200 BERTRAM CIRCLE GLEN BURNIE, MD 21060

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MT. HEBRON CEMETERY
Date: MARCH 20, 2001
20c. Location - City or Town, State: WINCHESTER, VA

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: KIRKLEY-RUDDICK FUNERAL HOME P.A. 421 CRAIN HWY. S.E. GLEN BURNIE, MD 21061

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death):
a. SEPSIS
Due to (or as a consequence of):
b. ENDOCARDITIS (BACTERIAL + FUNGAL)
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Liva birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Data of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
26c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Felicia Nicholson Glenn M.D.
29c. License number: P14672
29d. Date signed (Month, Day, Year): 3/15/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): University Hospital 22 S. GREENE ST. BALT. MD. 21201 Felicia Nicholson-Glenn MD

**State Registrar**

31. Date filed (Month, Day, Year): MAR 26 2001
32. Registrar's Signature: [signature]

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09068

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Anita Rosalie Papparotto
2. Date of Death Month Dey Yeer: March 20, 2001
3. Time of Death: 9:02 PM
4a. Facility Name (If not institution, give street and number): Westminister Nursing Home & Rehabilitain Cntr.
4b. City, Town, or Location of Death: Westminister
4c. County of Death: Carroll

**Funeral Director**

5. Social Security Number: 213-01-9951
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. lest birthdey): 95 Yrs. | If Under 1 Yeer: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): 1/6/1906
9. Birthplece (State or Foreign Country): Italy

Usuel Residence of Decedent

10a. Stete: MD
10b. County: Carroll
10c. City, Town or Location: Westminister
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1234 Washington Road
10f. Zip Code: 21157
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Sales Person
16b. Kind of Business/Industry: Clothing Store

17. Father's Name (First, Middle, Last): (Unknown) Spinnato
18. Mother's Neme (First, Middle, Maiden Surname): Josephine Fazio

19a. Informent's Name/Reletionship (Type, Print): Margarita DiPietro/Daughter
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 2019 Arabian Dr. Finksburg, Maryland 21048

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, cremetory or other piece): Holy Redeemer Cemetery
Date: 3/23/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Neme and Address of Feciility: John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heert failure. List only one cause on each line.

Approximete Interval Between Onset and Deth

Immediate Cause (Finel diseese or condition resulting in deeth)
a. Pneumonia — 2 wks

Due to (or es a consequence of):
b. ASCVD — 20 yr

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Lest
Due to (or es a consequence of):
c. Dementia — 7 yr

Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Deth (Check only one): Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of injury - At home, ferm, street, fectory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Phyaician**: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end manner as stated. 2☐ **Medical Examiner**: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and piece, and due to the cause(s) end menner stated.

29b. Signeture end title of certifier: [signature]
29c. License number: D25443
29d. Dete signed (Month, Day, Yeer): 3-24-01

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print): John W. Middleton 688 Poole Road Westminster, Md 21157

**State Registrar**

31. Dete filed (Month, Dey, Yeer): MAR 2 6 2001
32. Registrer's Signeture: [signature] G Sparks

DHMH 16 Rev 6/95

---

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

01-1569-005
mnmr
Edward M. Rich, Jr.

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- State Registrar AMEND ITEM:# 20B PER F.H. G&93 3-27-01 WR

# Certificate of Death

Reg. No. 2001 09069

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Edward M. Rich, Jr.

2. Date of Death (Month, Day, Year): March 20, 2001

3. Time of Death: 1557 p M

4a. Facility Name (If not institution, give street and number): 1405 Clearstream Road, Apartment G

4b. City, Town, or Location of Death: Essex

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 219-90-2483

6. Sex: 1 X M 2 ☐ F

7. Age (In yrs. last birthday): 24 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 02-16-77

9. Birthplace (State or Foreign Country): MD

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 X Yes 2 ☐ No

10e. Street and Number: 1405 Clearstream Road

10f. Zip Coda: 21221

10g. Citizen of What Country?: USA

11. Marital Status: X 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: X

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 10th Grade

College (1-4or 5+): NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Driver

16b. Kind of Business/Industry: Budget Rental Co.

17. Father's Name (First, Middle, Last): Edward M. Rich, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Carolyn Baker

19a. Informant's Name/Relationship (Type, Print): Carolyn Baker

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1260 Sugarwood Circle Baltimore, MD 21221

20a. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory, or other place): ~~Holly Hills Cem.~~ VOSHELL MEMORIAL GARDENS

Date: 03-28-2001

20c. Location - City or Town, State: Essex, MD

21. Signature of Funeral Service Licensee: Gladys Wand

22. Name and Address of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Contact Gunshot Wound of Head

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ✓ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 X Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 X Yes 2 ☐ No

25. Was case referred to medical examiner? X Yes 2 ☐ No

28. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) at scene

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 X Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year): 3/20/01

28b. Time of Injury: 1545 M

28c. Injury at Work? 1 ☐ Yes 2 ✓ No

28d. Describe how injury occurred: Subject Shot Self

28e. Place of Injury - At home, farm, factory, office building, etc. (Specify): House

28f. Location (Street and Number or Rural Route Number, City or Town, State): Essex, Maryland

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. Pentamen, M.D.

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): March 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pentamen 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): MAR 26 2001

32. Registrar's Signature: Barbara B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

01-1572-510
crn
Tracy Robinson

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM 23a,27 per ME G795 051801 SS

# Certificate of Death

2001 09070
Reg. No.

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Tracy L. Robinson | March 21 2001 | 3:28 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Johns Hopkins Hospital | Baltimore | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-84-3397 | 1 X M 2 F | 36 Yrs. | | | 3-17-65 | MD |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | N/A | Baltimore | 1 X Yes 2 No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1731 N. Patterson Park | 21231 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 X Never Married 2 Married 3 Widowed 4 Divorced | 1 Yes 2 X No If Yes, Give Year or Dates: | 1 Yes 2 X No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 9th | | Installer | Ferguerson |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| West Robinson | Shirley Wallace |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Shirley Thompson/mother | 2424 Marbourne Ave-Apt. 2D, Balt., MD 21230 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | Mt. Zion Cem. | 3-24-2001 | Lansdowne, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ | Hari P. Close Funeral Service, PA 709 Tessier Street, Balt., MD 21201-1925 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. DILATED CARDIOMYOPATHY AND ATHEROSCLEROTIC CARDIOVASCULAR DISEASE | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1 Yes 2 No 9 Unknown | 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1 Yes 2 No 3 Probably 4 X Unknown | 1 X Yes 2 No | 1 Yes 2 No |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) | |
|---|---|---|
| 1 X Yes 2 No | Hospital: 1 Inpatient 2 X ER/Outpatient 3 DOA | Other: 4 Nursing Home 5 Residence 8 Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | M | 1 Yes 2 No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one)
1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Theodore M. King MD | O.C.M.E. | March 22, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
THEMORE M. King 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 2 6 2001 | ▶ Donna G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

2001 09071
Reg. No.

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Ralph Joseph Raivel Sr. | March 22, 2001 | 3:07 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 2636 Openshaw Road | White Hall | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-28-2656 | 1☒M 2☐F | 69 Yrs. | | | 9/30/1931 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Baltimore | White Hall | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 913 Bernoudy Road | 21161 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 2 | Manager | Digital Computer |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| George F. Raivel | Iona Walter |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Marjorie Raivel/Wife | 425 Deerhill Circle Abingdon, Maryland 21009 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Gardens of Faith | 3/24/01 | Baltimore, Maryland |

21. Signature of Funeral Service Licensee

22. Name and Address of Facility: John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Renal Failure/Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) Daughters

27. Manner of Death 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Daniel Hugh Collector, MD | D44271 | 3/23/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Daniel Hugh Collector MD. 35 E. Padonia Road Timonium, Maryland 21093

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 26 2001 | Geneva G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09072

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): LEONARD ROCHLIN
2. Date of Death Month: MARCH Day: 20 Year: 2001
3. Time of Death: 10:36 PM
4a. Facility Name (If not institution, give street and number): RUXTON - PIKESVILLE NURSING HOME
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 358-10-9168
6. Sex: 1 XX M 2 ☐ F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): OCT. 20, 1919
9. Birthplace (State or Foreign Country): OHIO

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 XX Yes 2 ☐ No
10e. Street and Number: 6310 GREENSPRING AVENUE #101
10f. Zip Code: 21209
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 XX Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XX No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1 ☐ Yes XX No Specify:
14. Race - American indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4
16a. Decadant's Usual Occupation (Give kind of work done duning most of working life. DO NOT use ratired): SELF-EMPLOYED ARTIST
16b. Kind of Business/Industry: GRAPHIC ARTIST

17. Father's Name (First, Middle, Last): BENJAMIN ROCHLIN
18. Mothar's Name (First, Middle, Meidan Surname): EVA GOLDFADIM

19a. Informant's Name/Relationship (Type, Print): GLORIA LONDON / SISTER
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code): 11 SLADE AVENUE #301 - BALTIMORE, MD 21208

20e. Method of Disposition: 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cramatory or other piece): SHAAREI TFILOH CONG.
Dete: 3/23/01
20c. Location - City or Town, State: WOODLAWN, MD

21. Signature of Funeral Service Licansee: ▶ Scott M. Cuttle
22. Name and Address of Facility: SOL LEVINSON + BROS., INC 8900 REISTERSTOWN RD. PIKESVILLE MD. 21208

**Physician /Medical Examiner**

23e. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Batween Onset and Death

Immediate Cause (Final diseese or condition resulting in death): a. Congestive Heart Failure
Due to (or as a consequence of):
Sequantially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last: b. Angina Pectoris
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other signficant conditions** contributing to death but not resulting in the underlying causa given in Part I.: Chronic Anemia; Mild Dementia

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No
24b. Wara autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case raferred to medical axaminer? 1 ☐ Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of injury (Month, Day Year)
28b. Tima of injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28a. Place of injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 ☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2 ☐ **Medical Examiner**: On the basis of axamination and/or investigation, in my opinion, deatth occurred at tha tima, data and place, and due to the cause(s) and mannar stated.
29b. Signeture end title of certifier: ▶ Robert B Knopsnider MD
29c. License number: D14753
29d. Dete signed (Month, Day, Year): 3/21/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 4000 Old Court Road, Pikesville, Maryland 21208

**State Registrar**

31. Date filed (Month, Dey, Year): MAR 26 2001
32. Registrar's Signeture: ▶ Barbara G Sparks

DHMH 16 Rev 6/95

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attanding Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0020**

**Division of Vital Records, P.O. Box 68760,**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 09073

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| Wilhelmina Rhodes | | | March | 6 | 2001 | 900 AM |
| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | | 4c. County of Death | | | |
| 41 Straw Hat Rd. Apt 3A | Owings Mills | | Baltimore | | | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year Months | Days | If Under 24 Hrs. Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 216-20-7001 | 1☐M 2☒F | 92 Yrs. | | | | | 02/19/1909 | South Carolina |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | BALTIMORE | OWINGS MILLS | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 41 Straw Hat Rd. Apt. 3A | 21117 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 0 | CUSTODIAL | TELEPHONE COMPANY |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| SIMON RICHARDSON | JULIA LORANCE |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| CAROLYN R. RHODES (Daughter) | 41 Straw Hat Rd., Apt. 3A Owings Mills, MD 21117 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Cedar Hill Cemetery | 3/10/2001 | Glen Burnie, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Jonathan Hibner, per DVR | Phillips Funeral Home, PA 1721-27 N. Monroe St., Baltimore, MD 21217 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Metastatic Colon Cancer | 6 months |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☒No |

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one) — Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) — 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] MD | D0028146 | March 6 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Richard D Amewood Suite 240, 23 Crossroads Dr., Owings Mills Md 21117

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 2 6 2001 | [signature] G Sparks |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2001 09074

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Annie SPICER
2. Date of Death: Month March Day 19 Year 2001
3. Time of Death: 4:50 AM
4a. Facility Name (If not institution, give street and number): Millennium - Liberty Heights
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 238-12-9746
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): DEC. 30, 1911
9. Birthplace (State or Foreign Country): South Carolina

Usual Residence of Decedent

10a. State: md
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: ☒ 1 Yes 2 ☐ No
10e. Street and Number: 4104 Fairfax Rd
10f. Zip Code: 21216
10g. Citizen of What Country? U.S.A

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): COOK CHEF
16b. Kind of Business/Industry: Pharmacy

17. Father's Name (First, Middle, Last): Samuel BARR
18. Mother's Name (First, Middle, Maiden Surname): unknown

19a. Informant's Name/Relationship (Type, Print): Mary Watson - daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 404 Fairfax Rd. Balto. md. 21216

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Arbutus mem. PK Date: 3/24/01
20c. Location - City or Town, State: Arbutus md

21. Signature of Funeral Service Licensee: Lewis T. Gwynn — Lewis T. Gwynn
22. Name and Address of Facility: LEWIS T. Gwynn Funeral Home 4517 Park Heights Ave. Balto. md. 21215

Spicer, Annie B.
Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE RESPIRATORY FAILURE
Due to (or as a consequence of):
b. CHRONIC OBSTRUCTIVE PULMONARY
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of): DISEASE
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
END STAGE DEMENTIA
CHRONIC ANAEMIA

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Medical or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Tasneem Lakhani
29c. License number: D28595
29d. Date signed (Month, Day, Year): 3/23/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TASNEEM LAKHANI, 7220 PARK HEIGHTS AVE BALTO MD 21208

**State Registrar**

31. Date filed (Month, Day, Year): MAR 26 2001
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

RJD
DONALD B. SCHMIDT ADMEND ITEMS: #23 PART I, 27, 28A-F PER MEO G794 4-5-01 WR.
01-1613-005

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar ADMEND ITEM: #5 PER F.H. G793 3-26-01 WR

# Certificate of Death

2001 09075
Reg. No.

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|
| Donald Bruce Schmidt Jr. | MARCH 23, 2001 | 0237 A. M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 15303 HANOVER PIKE | UPPERCO | BALTIMORE |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| ~~218-52-5655~~ 215-82-5655 | 1 ☐ M 2 ☒ F | 34 Yrs. | | | Aug. 10, 1966 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Upperco | 1 ☐ Yes 2 ☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 15303 Hanover Pike | 21155 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: | 1 ☐ Yes 2 ☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Tile Setter | Ridge Contracting Co. |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Donald Bruce Schmidt Sr. | Patricia Anne Bonner |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Lisa Schmidt - wife | 15303 Hanover Pike, Upperco, Md. 21155 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Evergreen Mem. Gardens | March 26, 2001 | Finksburg, Md. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ J. Scott Eckhardt | Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, Md. 21117 |

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. POSITIONAL ASPHYXIA IN ASSOCIATION WITH SLEEP APNEA AND SEIZURE DISORDER | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery (Month, Day, Year) |
|---|---|---|
| 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown | 1 ☒ Yes 2 ☐ No | 1 ☒ Yes 2 ☐ No |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | | | | |
|---|---|---|---|---|---|
| 1 ☒ Yes 2 ☐ No | Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☒ Other (Specify) | SCENE | | |

| 27. Manner of Death | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☒ Pending investigation 6 ☐ Could not be determined | FOUND: 3-23-01 | FOUND: 2:03 A M | 1 ☐ Yes 2 ☒ No | SUBJECT WAS PINNED BETWEEN BED & WALL |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| FOUND: RESIDENCE | 15303 HANOVER PIKE UPPERCO, MD |

29a. Certifier (Check only one)
1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ | O.C.M.E. | MARCH 23, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mary G. Ripple, M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 26 2001 | ▶ Regina G. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 09076

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Virginia Elizabeth Simpkins
2. Date of Death: Month March Day 23rd Year 2001
3. Time of Death: 8:00 AM
4a. Facility Name *(If not institution, give street and number)*: NORTH ARUNDEL HOSPITAL
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: ANNE ARUNDEL

**Funeral Director**

5. Social Security Number: 219-12-5592
6. Sex: 1☐M 2☒F
7. Age *(In yrs. last birthday)*: 76 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: March 17, 1925
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Glen Burnie
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 542 Arundel Ave.
10f. Zip Code: 21061
10g. Citizen of What Country?: United States

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
18b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: William Mason Tudor
18. Mother's Name *(First, Middle, Maiden Surname)*: Fannie Mister

19a. Informant's Name/Relationship *(Type, Print)*: George A. Simpkins, Sr./Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 542 Arundel Ave., Glen Burnie, Maryland 21061

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Cedar Hill Cemetery — Date: March 27 2001
20c. Location - City or Town, State: Brooklyn Park, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, MD 21061

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Ischemic Cardiomyopathy

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other *(specify)* 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Chronic obstructive pulmonary disease,

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death *(Check only one)*: Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
26d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature], MD
29c. License number: D48006
29d. Date signed *(Month, Day, Year)*: March 23rd, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KOFI BUAITEY, 301 Hosp. Dr., Glen Burnie, MD 21061

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 2 6 2001
32. Registrar's Signature: [signature] D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

---

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

SIMPKINS, VIRGINIA

**Medical Certification; To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09077

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): LOUISE SMITH
2. Date of Death: Month MARCH Day 21 Year 2001
3. Time of Death: 8:36 PM
4a. Facility Name (If not institution, give street and number): GOOD SAMARITAN HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE.

**Funeral Director**

5. Social Security Number: 218-30-5632
6. Sex: 1☐ M 2☒ F XX
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 08-19-14
9. Birthplace (State or Foreign Country): VA

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: X☒ 1☒ Yes 2☐ No
10e. Street and Number: 346 East Federal Street
10f. Zip Code: 21202
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th Grade; College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Domestic
16b. Kind of Business/Industry: various trades

17. Father's Name (First, Middle, Last): Tom Jones
18. Mother's Neme (First, Middle, Meiden Surname): Unknown Jones

19a. Informant's Neme/Relationship (Type, Print): Gayle Robinson
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3628 Ednor Road Baltimore, Maryland 21218

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other placa): King Mem. Pk. Cem.
Date: 03-27-01
20c. Location - City or Town, State: Randallstown, MD

21. Signature of Funeral Service Licensee: ▶ Gladys Wane
22. Name end Address of Fecility: Baltimore, Maryland 21202
WM.C.March FH 1101E. North Avenue

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on eech line.

Approximete Interval Between Onset and Deeth

Immedlete Ceuse (Final disease or condition resulting in death)
a. PNEUMONIA — 5 days.

Due to (or as a consequenca of):
b. URINARY TRACT INFECTION. — 5 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, date and piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD
29c. License number: P13456
29d. Date signed (Month, Day, Year): March 21, 2001.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LISA S. MUNOZ 6920 DONACHIE Rd Apt 1609, Baltimore, MD

**State Registrar**

31. Date filed (Month, Day, Year): MAR 2 6 2001
32. Registrar's Signature: ▶

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09078

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Agnes Slavich
2. Date of Death (Month, Day, Year): 03-16-2001
3. Time of Death: 3:15 AM
4a. Facility Name (If not institution, give street and number): 12016 Devilwood Drive
4b. City, Town, or Location of Death: Potomac
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 141-18-9660
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10/29/1922
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Potomac
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 12016 Devilwood Drive
10f. Zip Code: 20854
10g. Citizen of What Country?: U.S.A

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Senior Manager
16b. Kind of Business/Industry: US FDA

17. Father's Name (First, Middle, Last): Martin Beleski
18. Mother's Name (First, Middle, Maiden Surname): Agatha (Unknown)

19a. Informant's Name/Relationship (Type, Print): Personal Stephen A. Liberatore-Rep.
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8922 Georgia Avenue, Silver Spring, MD.

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. Mary's Cemetery
Date: 03/19/01
20c. Location - City or Town, State: Pennsylvania

21. Signature of Funeral Service Licensee: ▶ Kim Schlanger MA21
22. Name and Address of Facility: Fleck Funeral Home 7601 Sandy Spring Road, Laurel, Maryland, 20707

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Lymphoma — 5 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Joseph M. Haggerty MD
29c. License number: 32407
29d. Date signed (Month, Day, Year): MARCH 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph M. Haggerty MD 9707 Medical Center Dr Rockville MD

**State Registrar**

31. Date filed (Month, Day, Year): MAR 2 6 2001
32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

88

15

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09079

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Laurance A. Sullivan

2. Date of Death — Month: March; Day: 20; Year: 2001

3. Time of Death: 8:25pm

4a. Facility Name (If not institution, give street and number): Charlestown care center

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 579-03-1504

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 84 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 1, 1916

9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 707 Maiden Choice Lane 9G22

10f. Zip Code: 21228

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Street Lighting Engineer

16b. Kind of Business/Industry: Utility

17. Father's Name (First, Middle, Last): Wellington Bernard Sullivan

18. Mother's Name (First, Middle, Maiden Surname): Susie Munger

19a. Informant's Name/Relationship (Type, Print): Vera Lorraine Sullivan / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 707 Maiden Choice Lane 9G22

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Bayview Crematory

Date: 3/22/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Michele N Vehda MO1241

22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. End stage congestive Heart failure — Months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Andres Salazar MD

29c. License number: D 51051

29d. Date signed (Month, Day, Year): March 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Andres Salazar 711 Maiden Choice Lane, Catonsville, MD 21228

**State Registrar**

31. Date filed (Month, Day, Year): MAR 26 2001

32. Registrar's Signature: ▶ Donna D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that this death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Name: Laurence Sullivan

01-1578-005
crn
Joseph Schmidt

1- For State Registrar

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09080

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Joseph John Schmidt, Sr. | March 21 2001 | 1128 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 1219 Ten Oaks Road | Arbutus | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-20-8471 | 1 [X] M 2 [ ] F | 74 Yrs. | | | Oct 20, 1926 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Arbutus | 1 [ ] Yes 2 [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1219 Ten Oaks Road | 21227 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Dates: | 1 [ ] Yes 2 [X] No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementery/Secondery (0-12) | College (1-4or 5+) | | |
| 12 | 6 | Staff Rep | Union |

| 17. Father's Neme (First, Middle, Last) | 18. Mother's Neme (First, Middle, Meiden Surname) |
|---|---|
| Alvin Schmidt | Marguerite Craft |

| 19a. Informant's Neme/Reletionship (Type, Print) | 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) |
|---|---|
| Marie E. Schmidt / wife | 1219 Ten Oaks Road, Arbutus, Maryland 21227 |

| 20a. Method of Disposition | 20b. Ptece of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Meadowridge Mem. Park | 3/26/2001 | Elkridge, Maryland |

21. Signature of Funeral Service Licensee: Ann Y. Zink

22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heert failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Finel diseese or condition resulting in death) | a. Arteriosclerotic Cardiovascular Disease | |
| | Due to (or as a consequenca of): | |
| Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last | b. | |
| | Due to (or as a consequenca of): | |
| | c. | |
| | Due to (or as a consequenca of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnent in the past 12 months? | 23c. If yes, outcome of pregnency | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1 [ ] Yes 2 [ ] No 9 [ ] Unknown | 1 [ ] Live birth 2 [ ] Fetal deeth 3 [ ] Ectopic pregnency 4 [ ] Pregnent et time of deeth 5 [ ] Other (specify) 9 [ ] Unknown | |

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No — Inspection

24b. Were autopsy findings available prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical exeminer? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) at scene

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] Yes 2 [ ] No | |

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred et the time, date end placa, and due to the cause(s) and mennar es stated. 2 [X] **Medical Examiner:** On the besis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| J. Pestaner M.D | O.C.M.E. | March 21, 2001 |

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Joseph Pestaner, M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 26 2001 | Brenda G. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 09081

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): WILLIAM JOHN STIELPER
2. Date of Death (Month, Day, Year): March 21, 2001
3. Time of Death: 8:47 P M
4a. Facility Name (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore County

**Funeral Director**

5. Social Security Number: 216-05-9371
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan 18, 1917
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 6613 Moyer Avenue
10f. Zip Code: 21206
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Terminal Manager
16b. Kind of Business/Industry: Trucking Company

17. Father's Name (First, Middle, Last): George John Stielper
18. Mother's Name (First, Middle, Maiden Surname): Mary Wilhemina Schilpp

19a. Informant's Name/Relationship (Type, Print): Patricia Supik (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 117 Beechbark Lane, Towson, Maryland 21286

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery | Date: 3/24/2001
20c. Location - City or Town, State: Parkville, Maryland

21. Signature of Funeral Service Licensee: Martin D. Lawson
22. Name and Address of Facility: Altenburg Funeral Home, P.A. 6009 Harford Road, Baltimore, Maryland 21214

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death):
a. SEPTIC SHOCK
Due to (or as a consequence of):
b. CANDIDA SEPTICEMIA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
RENAL FAILURE
CEREBROVASCULAR ACCIDENT

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
28. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28e. Date of Injury (Month, Day Year): NA
28b. Time of Injury: NA M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No: NA
28d. Describe how injury occurred: NA
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): NA
28f. Location (Street and Number or Rural Route Number, City or Town, State): NA

29e. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Serena Nolan MD
29c. License number: D25010
29d. Date signed (Month, Day, Year): 3/23/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Serina Nolan, M.D.,, 8831 Saytr Hill Road, Baltimore, Maryland 21234

**State Registrar**

31. Date filed (Month, Day, Year): MAR 26 2001
32. Registrar's Signature: Jeanne B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

---

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 09082

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| ALFRED | A. | SEIDER | MARCH 22, 2001 | 12:15 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| HOSPICE OF BALTIMORE - GILCHRIST | TOWSON | BALTIMORE |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 140-16-9704 | 1 X M 2 ☐ F | 78 Yrs. | | | MAY 6, 1922 | N.J. |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | BALTIMORE | SPARKS | 1 ☐ Yes 2 X No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1310 UPPER GLENCOE ROAD | 21152 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced | 1 X Yes 2 ☐ No If Yes, Give Year or Dates: WWII | 1 ☐ Yes 2 X No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | SALESMAN | CONSTRUCTION |

| 17. Father's Name (First, Middle, Last) | | 18. Mother's Name (First, Middle, Maiden Surname) | |
|---|---|---|---|
| SAMUEL | SEIDER | FANNIE | SILVERMAN |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| ALAN E. SEIDER / SON | 1310 UPPER GLENCOE ROAD - SPARKS, MD 21152 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | BETH TFILOH CEMETERY | 3/23/01 | WOODLAWN, MD |

21. Signature of Funeral Service Licensee ▶ Paul Levinson

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

ALFRED SEIDER MARCH 22, 2001 12:15A

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. acute leukemia | 4 months |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 ☐ Yes 2 X No | 1 ☐ Yes 2 ☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1 ☐ Yes 2 X No | Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) Hospice |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ Yes 2 ☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

29a. Certifier (Check only one) 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ W. Anthony Riley, MD | D25205 | March 22, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W. A. Riley GBMC 6701 N. Charles St. Balto. md 21204

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 2 6 2001 | ▶ Donna G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09083

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ALVIN STIEFEL

2. Date of Death: Month March Day 22 Year 2001

3. Time of Death: 0326

4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death: RANDALLSTOWN

4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 215-10-9773

6. Sex: 1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday): 87 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): DEC. 15, 1913

9. Birthplace (State or Foreign Country): VA

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 725 MT. WILSON LANE #601

10f. Zip Code: 21208

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? ☒ Yes 2 ☐ No If Yes, Give Year or Dates: ARMY

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MANAGER

16b. Kind of Business/Industry: INSURANCE

17. Father's Name (First, Middle, Last): HERMAN STIEFEL

18. Mother's Name (First, Middle, Maiden Surname): ROSE STERN

19a. Informant's Name/Relationship (Type, Print): BERTY STIEFEL / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 725 MT. WILSON LANE #601 - BALTIMORE, MD 21208

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): HAR SINAI CEMETERY

Date: 3/23/01

20c. Location - City or Town, State: OWINGS MILLS, MD

21. Signature of Funeral Service Licensee: Robert Levinson

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ASCVD

Due to (or as a consequence of):

b. AFib

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. HTN

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dr Laura Harlan

29c. License number: H0051339

29d. Date signed (Month, Day, Year): 3/22/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Laura J. Harlan 9401 Old Court Rd. Randallstown MD 21133

**State Registrar**

31. Date filed (Month, Day, Year): MAR 2 6 2001

32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24-hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 09081

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Louise W. Tracy
2. Date of Death Month: March Day: 21, Year: 2001
3. Time of Death: 10:48 P. M
4a. Facility Name (If not institution, give street and number): Edenwald
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore Co.

**Funeral Director**

5. Social Security Number: 218-09-5278
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 99 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): February 26, 1902
9. Birthplace (State or Foreign Country): Baltimore, Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore Co.
10c. City, Town or Location: Towson
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 800 Southerly Road
10f. Zip Code: 21286
10g. Citizen of Whet Country?: United States of America

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Home Maker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Henry Weber
18. Mother's Name (First, Middle, Maiden Surname): Mary Kamm

19a. Informant's Name/Relationship (Type, Print): Mrs. Dorothy Fleury (Niece)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11300 Raphel Road P.O. Box186 Upper Falls, Maryland 21156-0186

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery
Date: 3/24/2001
20c. Location - City or Town, State: Parkville, Maryland

21. Signature of Funeral Service Licensee: Jeffrey L. Gair, Sr.
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204-2515

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. PNEUMONIA — 2 wks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one) 1☒ Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of Certifier
29c. License number: D27838
29d. Date signed (Month, Day, Year): 3/23/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOHN SHAVERS, D.O. 5518 CAMP MEADE RD. LINTHICUM, MD 21090

**State Registrar**

31. Date filed (Month, Day, Year): MAR 26 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09085

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): KATHRYN TONE
2. Date of Death: Month March Day 20 Year 2001
3. Time of Death: 2100
4a. Facility Name (If not institution, give street and number): Howard County General Hospital
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

**Funeral Director**

5. Social Security Number: 102-05-0794
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug 30, 1913
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Elkridge
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6335 Greenfield Road, Unit #1709
10f. Zip Code: 21075
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): John Lyons
18. Mother's Neme (First, Middle, Maiden Surname): Alice McEnaney

19a. Informent's Name/Relationship (Type, Print): Carol Ann Bachman / daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6335 Greenfield Road, Unit #1709 Elkridge, Maryland 21075

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Nama of cemetery, crematory or other piece): Maryland Veterans Cem.
Date: 3/27/01
20c. Location - City or Town, Stata: Garrison, Maryland

21. Signature of Funeral Service Licansee: Ann G. Zink
22. Nama and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumothorax — HRS
Due to (or as a consequence of):
b. Pneumonia — Days

Sequentially list conditions, If any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.
Coronary Artery Disease

23b. Did tobacco use contribute to the causa of death? 1☐ Yaa 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yas 2☒ No

25. Was casa referred to medical examiner? 1☐ Yes 2☒ No
26. Placa of Death (Check only one): Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Phyaician**: To the best of my knowledge, death occurred at the time, dete and place, and due to the ceuse(s) and menner as stated. 2☐ **Medicaf Examiner**: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, end due to the cause(s) and menner stated.
29b. Signature and title of certifier: Pritam Saini MD
29c. Licensa number: D28948
29d. Date signed (Month, Day, Year): March 21, 2001
30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): PRITAM S SAINI MD 9101 Cherry Lane Suite 211 Laurel MD 20708

**State Registrar**

31. Date filed (Month, Day, Year): MAR 26 2001
32. Registrar's Signeture: Lenora G. Loaks

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09086

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): HILDA NOLTE WILSON
2. Date of Death (Month, Day, Year): March 22, 2001
3. Time of Death: 9:20 AM
4a. Facility Name (If not institution, give street and number): Edenwald Nursing Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 213-26-1104
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 95 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 22, 1905
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Towson
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 800 Southerly Rd.
10f. Zip Code: 21286
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner
16b. Kind of Business/Industry: Wilson Electric Co.

17. Father's Name (First, Middle, Last): William Thomas Nolte
18. Mother's Name (First, Middle, Maiden Surname): Margarite Fowble

19a. Informant's Name/Relationship (Type, Print): Mrs. Bjorg O. Wilson/DIL
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6107 Greentree Rd. Bethesda, MD 20817

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Pleasant Grove Cemetery
Date: 3/31/01
20c. Location - City or Town, State: Reisterstown, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD 21204

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. ALZHEIMERS DEMENTIA | 10yrs |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: 027838
29d. Date signed (Month, Day, Year): 3/22/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOHN SHAVERS, 5 SCAMP MEADOW RD, LUTHERVILLE, MD 21093

**State Registrar**

31. Date filed (Month, Day, Year): MAR 26 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

WILSON, HILDA N. 3/28/01

9:20 AM

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09087

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): EUGENE WATERS

2. Data of Death Month: MARCH Day: 18 Year: 2001

3. Time of Death: 0644

4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 218-64-0998

6. Sex: 1☐ M 2☐ F

7. Age (In yrs. last birthday): 44 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 12/29/1956

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☑ Yes 2☐ No

10a. Street and Number: 404 N. Lakewood Ave.

10f. Zip Code: 21224

10g. Citizen of What Country?: U.S. of A.

11. Marital Status: 1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+): Unk-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Stock Clerk

16b. Kind of Business/Industry: Hospital

17. Father's Name (First, Middle, Last): Phillip Jerome Williams

18. Mother's Name (First, Middle, Maiden Surname): Hattie Roseatta Waters

19a. Informant's Name/Relationship (Type, Print): Rita Waters (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 404 N. Lakewood Ave. Balto, Md. 21224

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion Cemetery

Date: 3/22/01

20c. Location - City or Town, State: Balto., Md.

21. Signature of Funeral Service Licensee: Lewis T. Gwynn

22. Name and Address of Facility: Lewis T. Gwynn Funeral Home 4517 Park Hghts. Ave 21215

**Physician /Medical Examiner**

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. SEPSIS — EIGHT HOURS

Due to (or as a consequence of):
b. PNEUMONIA — TWO DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. HIV — FOUR YEARS

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: RES-000

29d. Date signed (Month, Day, Year): MARCH 18 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BENJAMIN S. HERMAN MD, 600 NORTH WOLFE STREET, BALTIMORE MD 21287

**State Registrar**

31. Date filed (Month, Day, Year): MAR 26 2001

32. Registrar's Signature: G. Sparks

ORIGINAL

DHMH 16 Rev 6/95

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No.

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Harry Leroy Wheeler

2. Date of Death Month: March Day: 25 Year: 2001

3. Time of Death: 6:00 am.

4a. Facility Name *(If not institution, giva street and number)*: Brightwood Center

4b. City, Town, or Location of Death: Lutherville

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 215-30-0640

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 67 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct. 1, 1933

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Finksburg

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 2874 Talbert Rd.

10f. Zip Code: 21048

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedant Evar in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Giva Yeer or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12 | Collega (1-4or 5+): 1

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Vice President

16b. Kind of Business/Industry: Raloid Corp.

17. Father's Neme *(First, Middle, Last)*: Leroy Elsworth Wheeler

18. Mother's Neme *(First, Middle, Maiden Surname)*: Mary Margaret Neubeck

19a. Informent's Neme/Relationship *(Type, Print)*: Julia Wheeler - wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stata, Zip Code)*: 2874 Talbert Rd. Finksburg, Md. 21048

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from Stete 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Dulaney Valley Mem. Gardens

Date: March 28, 2001

20c. Location - City or Town, Stete: Timonium, Md.

21. Signature of Funeral Service Licensee: J. Gatte Eckhardt

22. Nama and Address of Facility: Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, Md. 21117

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complicetions thet caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or haart tailura. List only one cause on each line.

Approximata Interval Between Onset and Death

Immedieta Ceuse (Final disease or condition resulting in death): a. ESOPHOGEAL CARCINOMA. — 1 YR

Dua to (or as a consequance of):

Sequentially list conditions, if any, leading to immedieta cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Last

b. Due to (or as e consequance ot):

c. Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

METASTATIC CA TO BRAIN / LUNG

23b. Did tobacco use contributa to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only ona)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To tha best of my knowledga, daath occurred at tha tima, data and place, end dua to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, daath occurred at the time, date and piece, and dua to the cause(s) and menner stated.

29b. Signature and title of certifier: Raymond F. Capozzi, M.D.

29c. License number: D 024601

29d. Date signed *(Month, Day, Year)*: 3/26/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAYMOND F. CAPOZZI, M.D. 103d GREEN TREE RD. BALTO. MD. 21208

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 26 2001

32. Registrar's Signature: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

2001 09089 Reg. No.

Williams, Margaret March 24, 2001 8:15a.m.

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| Margaret | Ellen | Williams | March 24 2001 | 8:15am M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Gilchrist Ceneter | Baltimore | N/A |

**Funeral Director**

| 5. Social Security Number | 8. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 219-12-7570 | 1☐M 2☒F | 76 Yrs. | | | 04/27/1924 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Baltimore | Timonium | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2120 Sweet Briar Lane | 21053 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 11 | | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| John Ruddy | Mary |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Eugene Williams Husband | P.O. Box 1594 Lake Placid, FL 33862 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Balto. Wash. Crematory | 3/26/01 | Laurel, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Peter L. Ashton Schwab II | Sterling Ashton Schwab Fun. Home 736 Edmondson Avenue Catonsville, MD 21228 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. ruptured Abdominal Aortic Aneurysm | 3 weeks |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | Month / Day / Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 8☒Other (Specify) Hospice |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ W. Anthony Riley, MD | D25205 | March 24, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
W. A. Riley GBMC 6701 N. Charles St. Balto. md 21204

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 2 8 2001 | ▶ |

DHMH 17 Rev 1/2001

ORIGINAL

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09090

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): William J Wells
2. Date of Death: Month March Day 21 Year 2001
3. Time of Death: 10:13AM
4a. Facility Name (If not institution, give street and number): Balto VAMC Rehab/Extended Care
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

**Funeral Director**

5. Social Security Number: 218-03-9932
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 90 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 1/15/1911
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Harford
10c. City, Town or Location: Joppa
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 508 Haverhill Road
10f. Zip Code: 21085
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Signal Repairman
16b. Kind of Business/Industry: Railroad

17. Father's Name (First, Middle, Last): John Wells
18. Mother's Name (First, Middle, Maiden Surname): Alberta Murray

19a. Informant's Name/Relationship (Type, Print): Lelia Coffey
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 508 Haverhill Road Joppa, Maryland 21085

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Balto/Wash. Crematory
Date: 3/26/01
20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Prostate Cancer — 3 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☑Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D37070
29d. Date signed (Month, Day, Year): March 21, 2001

30. Name and address of person who completed cause of death (item 23a) (Type, Print): David J Lorecki M.D. Balto VAMC Rehab/Extended Care

**State Registrar**

31. Date filed (Month, Day, Year): MAR 2 6 2001
32. Registrar's Signature: [signature]

ORIGINAL

DHMH 16 Rev 6/95

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09091

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Ellen R. White
2. Date of Death Month Day Year: 3/20/2001
3. Time of Death: 6AM.
4a. Facility Name (If not institution, give street and number): 2616 Pierpont St.
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: City

**Funeral Director**

5. Social Security Number: 214-58-7246
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 57 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12/23/43
9. Birthplace (State or Foreign Country): Baltimore, Md.

Usual Residence of Decedent

10a. State: Md.
10b. County: City
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2616 Pierpont St.
10f. Zip Code: 21230
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Clarence Johnson
18. Mother's Name (First, Middle, Maiden Surname): Hannah Johnson

19a. Informent's Name/Relationship (Type, Print): Wanda C. WHite
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2616 Pierpont Street, Baltimore, Md. 21230

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion Cemetery
Date: 3/24/01
20c. Location - City or Town, State: Lansdowne, Md.

21. Signature of Funeral Service Licensee: ▶ Lloyd M. Estep
22. Name and Address of Facility: Estep Brothers Funeral Ser, P.A. 1300 Eutaw Place, Baltimore, Md. 21217

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Lung Cancer — 6 mo
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☒ Residance 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner**: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, dete end piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD
29c. License number: D0056065
29d. Date signed (Month, Day, Year): 3/23/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. N. Elleman 22 S. Greene St, Baltimore, Md. 21201

**State Registrar**

31. Date filed (Month, Day, Year): MAR 26 2001
32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

---

**Division of Vital Records, P.O. Box 68768, Baltimore, Maryland 21215-0020**

**To be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09092

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Shirley H. Bradley

2. Date of Death: Month March Day 8 Year 2001

3. Time of Death: 5:30 P.M.

4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 165-03-0122

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 12, 1919

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 9200 Franklin Square Drive

10f. Zip Code: 21237

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, Whita, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired): Waitress

16b. Kind of Business/Industry: Restaurant

17. Father's Name (First, Middle, Last): John Little

18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Gill

19a. Informant's Name/Relationship (Type, Print): Mrs. Karen Hardnock (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8942 Kilkenny Circle, Baltimore, MD 21236

20a. Mathod of Disposition: 1☐ Burial 2☐ Cremation 3☒ Ramoval from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. Josephs Cemetery

Date: 3/13/01

20c. Location - City or Town, State: Ashland, PA

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complicetions thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart leilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initieted events rasulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other signilicant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia, Encephalopathy

Seizure Disorder, Bipolar Disorder

Cerebrovascular Accident

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end pleca, end due to the cause(s) and manner stated.

29b. Signatura and title of certifier: [signature] Marco Zamora MD

29c. Licanse number: D40819

29d. Date signed (Month, Day, Year): March 8 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Marco Zamora 9000 Franklin Square Dr. Baltimore Maryland 21237

**State Registrar**

31. Date filed (Month, Day, Year): MAR 9 - 2001

32. Registrar's Signature: [signature]

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Division of Vital Records, P.O. Box 68760,**

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09093

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Norma Louise Bernard

2. Date of Death (Month, Day, Year): March 7, 2001

3. Time of Death: 6:53 PM

4a. Facility Name (If not institution, give street and number): Joseph Richey Hospice

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 213-20-3221

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 15, 1925

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 513 S. Ponca Street

10f. Zip Code: 21224

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 9th Grade

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Waitress

16b. Kind of Business/Industry: Restaurant

17. Father's Name (First, Middle, Last): Henry Bernard

18. Mother's Name (First, Middle, Maiden Surname): Filomena Sari

19a. Informant's Name/Relationship (Type, Print): Mr. Henry V. Bernard (brother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9502 Dundawan Road, Baltimore, MD 21236

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Oak Lawn Cemetery

Date: 3/10/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Christina L. David

22. Name and Address of Facility: Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Carcinoma of colon with mets — 6 mo

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John W. Payne MD

29c. License number: D 130 12

29d. Date signed (Month, Day, Year): 3/8/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John W. Payne MD 6565 N. Charles St 21204

**State Registrar**

31. Date filed (Month, Day, Year): MAR 9 - 2001

32. Registrar's Signature: S. Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

6:53 pm

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3-7-01

Norma Bernard

2

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09094

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Lillie Alice Bradburn

2. Date of Death: Month March Day 11 Year 2001

3. Time of Death: 3:45PM

4a. Facility Name (If not institution, give street and number): Citizens Nursing Home

4b. City, Town, or Location of Death: Havre de Grace

4c. County of Death: Harford

**Funeral Director**

5. Social Security Number: 240-07-0522

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 12, 1908

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD

10b. County: Harford

10c. City, Town or Location: Havre de Grace

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2304 Nova Drive

10f. Zip Code: 21078

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: In home

17. Father's Name (First, Middle, Last): John McCraw

18. Mother's Name (First, Middle, Maiden Surname): Lucy Johnson

19a. Informant's Name/Relationship (Type, Print): Betty Jean Cudmore (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2304 Nova Dr., Havre de Grace, Maryland 21078

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Holly Hill Memorial Gdns. Date: 3/15/01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: ▶ Kenneth B. Cargo

22. Name and Address of Facility: Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Alzheimer Dementia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Hans Sam Kim

29c. License number: D37364

29d. Date signed (Month, Day, Year): March 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 19 Walnut Lane, Aberdeen, Maryland 21001

**State Registrar**

31. Date filed (Month, Day, Year): MAR 13 ...

32. Registrar's Signature: ▶ D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

Lillie Bradburn

8

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend #1 hchdS.Harris 3/13/2001 — *Certificate of Death* — Reg. No. 2001 09095

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| John | Calvin | Buckland | March 12, 2001 | 05 00 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| The Johns Hopkins Hospital | Baltimore City | ----- |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 232-58-1989 | 1 ☒ M 2 ☐ F | 62 Yrs. | | | Sept. 24, 1938 | W. Virginia |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Harford | Edgewood | 1 ☐ Yes 2 ☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1582 Harford Square Drive | 21040 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1956-76 | 1 ☐ Yes 2 ☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 2 | Postal Clerk | U.S. Postal Service |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Hollie Emmett Buckland | Edith Ellen Craft |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Fumie D. Buckland - Wife | 1582 Harford Square Dr., Edgewood, MD 21040 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Greenbrier Mem. Grdns. | 3/15/01 | Lewisburg, WV |

21. Signature of Funeral Service Licensee: Billy McComas Renta

22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Sepsis | 72 hrs |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnent in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown | 23d. Date of delivery Month / Day / Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease
End Stage renal disease

| 23e. Did tobecco use contribute to the ceuse of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of deelh? |
|---|---|---|
| 1 ☒ Yes 2 ☐ No 3 ☐ Probebly 4 ☐ Unknown | 1 ☐ Yes 2 ☒ No | 1 ☐ Yes 2 ☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 ☐ Yes 2 ☒ No | Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ Yes 2 ☐ No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| | RES-000 | 3/12/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jay Shuke, M.D. 8202 Fernhill Rd. Perry Hall, MD 21128

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 13 2001 | |

DHMH 17 Rev 1/2001

ORIGINAL

---

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**To Be Completed by Physician/Medical Examiner**

**Medical Certification;**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09096

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Virginia E. Bristow

2. Date of Death (Month, Day, Year): March 14, 2001

3. Time of Death: 3:35 PM

4a. Facility Name (If not institution, give street and number): Mariner Health Care of Laurel

4b. City, Town, or Location of Death: Laurel

4c. County of Death: Prince George

**Funeral Director**

5. Social Security Number: 217-46-8841

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 54 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 23, 1946

9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: MD

10b. County: Prince George

10c. City, Town or Location: Laurel

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 14200 Laurel Park Drive

10f. Zip Code: 20707

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): Ø

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): William S. Church

18. Mother's Name (First, Middle, Maiden Surname): Virginia W. Worrell

19a. Informant's Name/Relationship (Type, Print): Kathy A. Goodman /sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8931 Cotton Grass Street, Waldorf, Maryland 20603

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory, Inc.

Date: 3/16/01

20c. Location - City or Town, State: Catonsville, Maryland

21. Signature of Funeral Service Licensee: [signature] M00773

22. Name and Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Acute Myocardial Infarction | 3-14-01 |
| Due to (or as a consequence of): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. | Diabetes Mellitus | 10-24-77 |
| Due to (or as a consequence of): | | |
| c. | Azotaemia | |
| Due to (or as a consequence of): | | |
| d. | Depression | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D0013668

29d. Date signed (Month, Day, Year): March 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Azher Hussain, M.D. 4917 Edgewood Road, College Park, Maryland 20740-1493

**State Registrar**

31. Date filed (Month, Day, Year): MAR 19 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

---

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

01-1272-001
CJ
Jeffrey M. Beard

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 09097

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|---|
| Jeffery | Mark | Beard | Sr. | March | 06 | 2001 | 09:50 A.M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 10510 Steigmaier Lane | Cumberland | Allegany |

**Funeral Director**

| 5. Social Security Number | 8. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 213-72-2622 | 1☐M 2☐F X | 40 Yrs. | | | | | Nov 9, 1960 | Washington, D.C. |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Allegany | Cumberland | 1☐Yes 2☐No X |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 10510 Stegmaier Lane | 21502 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced X | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☐No X Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | parole/probation dept | State of Maryland |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Bernard Beard | Mary Stegmaier |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Joseph Beard-brother<br>Mandy Beard-dtr | 15007 Fox Run Road;Oldtown MD 21555 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) X | Scarpelli Funeral Home | 3/09/2001 | Cresaptown, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Nicholas J. Scarpelli | Scarpelli Funeral Home, P.A.<br>Cumberland, MD 21502 |

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not entar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Finat disease or condition resulting in death) | a. CARBON MONOXIDE INTOXICATION | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequance of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☒Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 8☒Other (Specify) Scene

27. Manner of Death: 1☐Natural 2☐Accident 3☒Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| FOUND 3/6/01 | FOUND 910 A M | 1☐Yes 2☒No | SUBJECT ATTACHED HOSE TO TAILPIPE OF CAR INTO THE WINDOW OF CAR |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| DRIVEWAY OF RESIDENCE | 10510 STEIGMAIER LANE, CUMBERLAND, MD |

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at tha time, date and placa, and dua to the cause(s) and mannar as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| M.D. | O.C.M.E. | March 7, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARY G. RIPPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

6

**State Registrar**

31. Date filed (Month, Day, Year): MAR 08 2001

32. Registrar's Signature: Brenda G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2001 09098

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Nellie Louise Bunnell
2. Date of Death Month / Day / Year: March 14, 2001
3. Time of Death: 10:12 a.m.
4a. Facility Name *(If not institution, give street and number)*: Memorial Hospital & Medical Center
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

**Funeral Director**

5. Social Security Number: 234-01-7456
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 84 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jan 9, 1917
9. Birthplace *(State or Foreign Country)*: WV

Usual Residence of Decedent

10a. State: MD
10b. County: Allegany
10c. City, Town or Location: Cumberland
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 15 N. Lee Street
10f. Zip Code: 21502
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Rece - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usuat Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Control Inspector
16b. Kind of Business/Industry: Aircraft Company

17. Father's Name *(First, Middle, Last)*: Joseph C. Griffith
18. Mother's Name *(First, Middle, Meiden Surname)*: Mary C Whittington

19a. Informant's Name/Relationship *(Type, Print)*: Sherry Merica friend
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 12009 Amherst Avenue;Cumberland MD 21502

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other piece)*: Cedar Lawn Memorial Pa
Date: 3/16/2001
20c. Location - City or Town, State: Hagerstown, MD

21. Signature of Funeral Service Licensee: Nicholas J Scarpelli
22. Name and Address of Facility: Scarpelli Funeral Home, P.A. Cumberland, MD 21502

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediete Cause (Finel disease or condition resulting in death)
a. Aspiration Pneumonia — 3 hours
Due to (or as a consequence of):

Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part tt. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia, Coronary Artery Disease

23b. Did tobacco uas contributa to the causa of death? 1☐ Yaa 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end piece, and due to the cause(s) and menner steted.

29b. Signature and title of certifier:
29c. License number: D0033280
29d. Dete signed *(Month, Day, Year)*: March 14, 2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Sunil K. Gupta 625 Kent Avenue Suite 101 Cumberland, MD 21502

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 15 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09099

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Georgianna Cooper

2. Date of Death: Month March, Day 10, Year 2001

3. Time of Death: 10:30 AM

4a. Facility Name (If not institution, give street and number): Calvert Manor Nursing Home

4b. City, Town, or Location of Death: Rising Sun

4c. County of Death: Cecil

**Funeral Director**

5. Social Security Number: 220-22-0680

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 96 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 6, 1904

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Cecil

10c. City, Town or Location: Rising Sun

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1881 Telegraph Road

10f. Zip Code: 21911

10g. Citizen of What Country: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): U/K; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Domestic Engineer

16b. Kind of Business/Industry: Someone Else's Home

17. Father's Name (First, Middle, Last): Ellsworth (u/k) Cooper

18. Mother's Name (First, Middle, Maiden Surname): Arsenia (u/k) (u/k)

19a. Informant's Name/Relationship (Type, Print): Vanessa Hickman- Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 134 South Archer Street, Bel Air, Maryland 21014

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Hosanna AME Cemetery

Date: 3-15-01

20c. Location - City or Town, State: Darlington, Maryland

21. Signature of Funeral Service Licensee: Kelly McComas Reuter

22. Name and Address of Facility: McComas Funeral Home, P.A. 50 W. Broadway Street, Bel Air, Maryland 21014

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. Arteriosclerotic heart disease — 3 yrs.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Neil Taylor MD

29c. License number: D-11115

29d. Date signed (Month, Day, Year): 3-10-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Neil Taylor MD Calvert Healthcare Center Rising Sun, MD 21911

**State Registrar**

31. Data filed (Month, Day, Year): MAR 13 2001

32. Registrar's Signature

DHMH 16 Rev 6/95

---

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0020**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Division of Vital Records, P.O. Box 68760,**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg No. 2001 09100

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): PAUL JOSEPH CIULLA
2. Date of Death (Month, Day, Year): MARCH 08 2001
3. Time of Death: 12:30 AM
4a. Facility Name (If not institution, give street and number): Saint Joseph Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 213-16-4663
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 78 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 23, 1922
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 6 Juliet Lane, Unit 303
10f. Zip Code: 21236
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7th Grade — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Barber
16b. Kind of Business/Industry: Barber Shop

17. Father's Name (First, Middle, Last): Joseph Ciulla
18. Mother's Name (First, Middle, Maiden Surname): Esther Mangione

19a. Informant's Name/Relationship (Type, Print): Mrs. Mary C. Ciulla (wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6 Juliet Lane, Unit 303, Baltimore, MD 21236

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens of Faith Cem.
Date: 3/12/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Brian A. Willen
22. Name and Address of Facility: Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death):
a. VENTRICULAR FIBRILLATION

Due to (or as a consequence of):
ISCHEMIC CARDIOMYOPATHY

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ACUTE RENAL FAILURE

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D38882
29d. Date signed (Month, Day, Year): 3/8/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KHALID AL-TALIB M.D., 827 LINDEN AVE, BALTIMORE, MARYLAND 21201

**State Registrar**

31. Date filed (Month, Day, Year): MAR 9 - 2001
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Amended items #3, 23b, (per M.D.) TCHD, 3/5/01, sbb

# Certificate of Death

Reg. No. 2001 02101 2412

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): JOHN A. CARPENTER

2. Date of Death: Month 2, Day 27, Year 2001

3. Hour of Death: 0-2812

4a. Facility Name (If not institution, give street and number): UNIVERSITY OF MARYLAND

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: BALTIMORE CITY

**Funeral Director**

5. Social Security Number: 195-12-2435

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 2, 1924

9. Birthplace (State or Foreign Country): France

Usual Residence of Decedent

10a. State: Maryland

10b. County: Talbot

10c. City, Town or Location: Tilghman

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10a. Street and Number: 21682 Camper Circle

10f. Zip Code: 21671

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yaar or Dates: WWII Army Air Corps

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Reca - American Indian, Black, White, etc. Specify: White

15. Decedant's Education (Specify only highest grade complated): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 10

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Prof. Psychology

16b. Kind of Businass/Industry: Rutgers Univ.

17. Father's Neme (First, Middle, Last): Harry Carpenter

18. Mother's Name (First, Middle, Maiden Surnama): Jeanne Dannals

19a. Informant's Name/Ralationship (Type, Print): Marilyn Z. Carpenter Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda): 21682 Camper Circle Tilghman, Maryland 21671

20a. Method of Disposition: 1 [ ] Buriel 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cramatory or other place): Capitol Crematory | Data: March 1, 2001

20c. Location - City or Town, Stete: Dover, Delaware

21. Signeture of Funeral Service Licensee: Harrison E. Leonard

22. Name and Address of Fecility: Harrison E. Leonard Funeral Home, 312 S. Talbot St. St. Michaels, Maryland 21663

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complicetions thet caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only ona causa on aach line. | Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)
a. CARDIOPULMONARY ARREST — 20 MIN

Due to (or as a consequence of):
Myocardial Infarction

Sequentially list conditions, if any, leading to immediele cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or es e consequence of):
c. Due lo (or as a consequence of):
d.

Part II. **Other signifiicant conditiona** contributing to death but not resulting in the underlying cause given in Part i.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yee 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24e. Was en autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yas 2 [✓] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only ona): Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Rasidance 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to tha causa(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and place, and dua to tha cause(s) and menner stated.

29b. Signature and title of certifier: C. M. Henderson MD

29c. License number: P12753

29d. Date signed (Month, Day, Year): 2-27-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JAMES HENDERSON 22 S. GREENE ST BALTIMORE MD 21201

**State Registrar**

31. Date filed (Month, Day, Year): MAR 0 5 2001

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09102

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Tevis Lavern Cornish

2. Date of Death: Month 03 Day 12 Year 2001

3. Time of Death: 04:56

4a. Facility Name (If not institution, give street and number): Dorchester General Hospital

4b. City, Town, or Location of Death: Cambridge

4c. County of Death: Dorchester

**Funeral Director**

5. Social Security Number: 219-70-8140

6. Sex: 1☐ M 2☑ F

7. Age (In yrs. last birthday): 41 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 29, 1960

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Dorchester

10c. City, Town or Location: Cambridge

10d. Inside City Limits: 1☑ Yes 2☐ No

10e. Street and Number: 408 High Street

10f. Zip Code: 21613

10g. Citizen of What Country? USA

11. Marital Status: 1☑ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Production Worker

16b. Kind of Business/Industry: Manufacturing

17. Father's Name (First, Middle, Last): Randall Emile Cornish

18. Mother's Name (First, Middle, Maiden Surname): Mary Magalene Keene

19a. Informant's Name/Relationship (Type, Print): Rhonda Cornish

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 406 Leonard's Lane Cambridge, Maryland 21613

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Beckwith Cemetery

Date: 3/16/2001

20c. Location - City or Town, State: Cambridge, Maryland

21. Signature of Funeral Service Licensee: ▶ Janelle C. Henry

22. Name and Address of Facility: Henry Funeral Home P.A. 510 Washington Street Cambridge, Maryland 21613

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. RENAL FAILURE | 48 hours |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | b. HYPOTENSION | 48 hours |
| | Due to (or as a consequence of): | |
| | c. SEPSIS | 48 hours |
| | Due to (or as a consequence of): | |
| | d. PNEUMONIA | 72 hours |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

MALNUTRITION

ILEUS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD

29c. License number: D53253 MD

29d. Date signed (Month, Day, Year): 3/12/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Timothy J. Snierzek MD 503 A Muir St Cambridge, MD 21613

**State Registrar**

31. Date filed (Month, Day, Year): MAR 13 2001

32. Registrar's Signature: ▶ Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09103

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: William Russell Cutter
2. Date of Death Month Day Year: March 04, 2001
3. Time of Death: 9:00 A.M.
4a. Facility Name *(If not institution, give street and number)*: Moran Manor Nursing Home
4b. City, Town, or Location of Death: Westernport
4c. County of Death: Allegany

**Funeral Director**

5. Social Security Number: 219-14-5949
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 07, 1923
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Allegany
10c. City, Town or Location: Midland
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 14902 Paradise Street
10f. Zip Code: 21542
10g. Citizen of Whet Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1943
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Automobile
16b. Kind of Business/Industry: Inspection

17. Father's Name *(First, Middle, Last)*: Russell Cutter
18. Mother's Name *(First, Middle, Maiden Surname)*: Helen Stewart

19a. Informent's Name/Reletionship *(Type, Print)*: Raymond P. Cutter-nephew
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 15231 New Georges Creek Rd.S.W., Frostburg,Md. 21532

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Frostburg Memorial Park
Date: March 06, 2001
20c. Location - City or Town, State: Frostburg,Md.

21. Signature of Funeral Service Licensee: ▶ Jana E. McKenzie
22. Name and Address of Facility: Eichhorn-McKenzie Funeral Home P.A.,Lonaconing,Md. 21539

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Myocardial Infarction — 15 hours
Due to (or as a consequence of):
b. Coronary Artery Disease — 15 years
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Dementia

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature]
29c. License number: D21244
29d. Date signed *(Month, Day, Year)*: 3/6/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jesus H. Tan, Frostburg Plaza, Frostburg, Md. 21532

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 0 6 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2001 09104

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: MICHAEL L. COOK
2. Date of Death Month: 3 Day: 15 Year: 2001
3. Time of Death: 11:05 a.m.
4a. Facility Name *(If not institution, give street and number)*: MEMORIAL HOSPITAL
4b. City, Town, or Location of Death: CUMBERLAND
4c. County of Death: ALLEGANY

**Funeral Director**

5. Social Security Number: 215-42-2644
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 57 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: SEPT 17, 1943
9. Birthplace *(State or Foreign Country)*: DISTRICT OF COLUMBIA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ALLEGANY
10c. City, Town or Location: FROSTBURG
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 204 E. MAIN STREET
10f. Zip Code: 21532
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: UNKNOWN
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 3
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SUPERVISOR
16b. Kind of Business/Industry: DRILLING

17. Father's Name *(First, Middle, Last)*: LLOYD COOK
18. Mother's Name *(First, Middle, Maiden Surname)*: BARBARA WEBSTER

19a. Informant's Name/Reletionship *(Type, Print)*: GAIL COOK-WIFE
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 204 E. MAIN ST., FROSTBURG, MD 21532

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from Stete 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: SILBAUGH CREMATORY
Date: MARCH 19, 2001
20c. Location - City or Town, State: UNIONTOWN, PA

21. Signature of Funeral Service Licensee: Douglas S Hafer
22. Name and Address of Facility: HAFER CHAPEL OF THE HILLS MORTUARY 1302 NATIONAL HWY, LAVALE, MD 21502

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Subarachnoid hemorrhage — 5days

Due to (or as a consequence of):
b. Anterior Cerebral Aneurysm — 5days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Rheumatoid Arthritis
type 2 diabetes Mellitus
hypertension

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D0054426
29d. Date signed *(Month, Day, Year)*: MARCH 15 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR MICHAEL ZANG 500 MEMORIAL AVE SUITE 105 CUMBERLAND, MD 21502

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 16 2001
32. Registrar's Signature: Brenda G Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

MICHAEL COOK 215-42-2644

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

3/1 MLS

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09105

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Eleanor, Donnelly

2. Date of Death: Month March, Day 09, Year 2001

3. Time of Death: 4:45 PM

4a. Facility Name (If not institution, give street and number): Mariner Health of Forest Hill

4b. City, Town, or Location of Death: Forest Hill

4c. County of Death: Harford

**Funeral Director**

5. Social Security Number: 213-20-3493

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): Jan. 22, 1914

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 8918 Carlisle Avenue

10f. Zip Code: 21236

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6th Grade; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Seamstress

16b. Kind of Business/Industry: Clothing Company

17. Father's Name (First, Middle, Last): George W. Hager

18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Oshse

19a. Informant's Name/Relationship (Type, Print): Mr. Herb Hasselbarth (nephew)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 611 Ponderosa Drive, Bel Air, MD 21014

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. Michael Lutheran CH.

Date: 3/13/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Mark T. Schimunek

22. Name and Address of Facility: Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. advanced dementia — <6m

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

possible sepsis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ David S. Dunn

29c. License number: D32275

29d. Date signed (Month, Day, Year): March 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID S DUNN 615 W. MacPhail Bel Air, MD 21014

**State Registrar**

31. Date filed (Month, Day, Year): MAR 12 2001

32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 9068.

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09106

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): EVELYN MARSHALL DAVIS
2. Date of Death: Month MARCH Day 8 Year 2001
3. Time of Death: 8:40 AM
4a. Facility Name (If not institution, give street and number): 644 ELIZABETH STREET
4b. City, Town, or Location of Death: EASTON
4c. County of Death: TALBOT

**Funeral Director**

5. Social Security Number: 212-66-1651
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 93 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): SEPT 12 1907
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: TALBOT
10c. City, Town or Location: EASTON
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 644 ELIZABETH STREET
10f. Zip Code: 21601
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME
17. Father's Name (First, Middle, Last): BERNARD MARSHALL
18. Mother's Name (First, Middle, Maiden Surname): CORA SHORT
19a. Informant's Name/Relationship (Type, Print): WENDELL E. DAVIS/ SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 22998 TUCKAHOE SPRINGS DR, DENTON, MD 21629
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, cramatory or other place): SPRINGHILL CEMETERY
Date: 3-12-01
20c. Location - City or Town, State: EASTON, MD 21601
21. Signature of Funeral Service Licensee: JOHN R. MERCERON CFSP
22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. MULTIPLE MYELOMA — Since 1995

Due to (or as a consequance of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequance of):

c. Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: PARKINSONS DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D31466
29d. Date signed (Month, Day, Year): 3/8/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LUDWIG J. EGLESEDER III, M.D. 606 DUTCHMANS LANE EASTON, MD 21601

**State Registrar**

31. Date filed (Month, Day, Year): MAR 09 2001
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

EVELYN M. DAVIS

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09107

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Florence Louise Davis
2. Date of Death Month Day Year: March 9, 2001
3. Time of Death: 5:40 A.M.
4a. Facility Name (If not institution, give street and number): Memorial Hospital & Medical Center
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

**Funeral Director**

5. Social Security Number: 219-14-5928
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 80 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 30, 1920
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Allegany
10c. City, Town or Location: Cumberland
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 220 Fulton Street
10f. Zip Code: 21502
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): John Elliott Smith
18. Mother's Name (First, Middle, Maiden Surname): Mary R. (Jones)

19a. Informant's Name/Relationship (Type, Print): Constance L Davis
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7308 Byeforde Ct., Springfield, VA 22150

20a. Method of Disposition: ☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Woodlawn Cemetery
Date: 3/12/01
20c. Location - City or Town, State: Cumberland, Maryland

21. Signature of Funeral Service Licensee: ▶ William B Kight DS
22. Name and Address of Facility: Kight Funeral Home, 309-311 Decatur St., Cumberland, MD 21502

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Anoxic Encephalopathy | 24 hours |
| Due to (or as a consequence of): b. | Myocardial Infarction | 48 hours |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c. | | |
| Due to (or as a consequence of): d. | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ William Lamm MD
29c. License number: D25406
29d. Date signed (Month, Day, Year): March 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. William Lamm, 47 Virginia Avenue, Cumberland, MD 21502

**State Registrar**

31. Date filed (Month, Day, Year): MAR 13 2001
32. Registrar's Signature: ▶ Donna B Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

FLORENCE DAVIS 219-14-5928

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

01-1411-001
crn
Jonathan Edwin Dolly

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- State Registrar

# Certificate of Death

Reg. No. 2001 09108

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| Jonathan | Edwin | Dolly | March | 12 | 2001 | 9:03 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Memorial Hospital | Cumberland | Allegany |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 218-06-0922 | 1☐M 2☐F X | 16 Yrs. | | | | | Aug 15, 1984 | MD |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| WV | Mineral | Ridgeley | 1☐Yes 2☐No X |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 82 Knobley Street | 26753 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) | 14. Rece - Americen Indian, Black, White, etc. |
|---|---|---|---|
| 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Yeer or Detes: | 1☐Yes 2☐No X Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 10 | | student | high school |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Carl Edwin Dolly | Pamela J (Propst) |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Carl E. Dolly parents | P.O. Box 151; Ridgeley WV 26753 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, cremetory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremetion 3☐Removal from Stete 4☐Donation 5☐Other (Specify) | Glendale Cemetery | 3/16/2001 | Flintstone, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ James F Scarpelli | Scarpelli Funeral Home, P.A. Cumberland, MD 21502 |

**Physician /Medical Examiner**

23a. Part I. Enter the diseese, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heert failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediete Cause (Finel disease or condition resulting in deeth) | a. Head Injuries | |
| Sequentially list conditions, if eny, leading to immediete ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Last | b. Due to (or as e consequence of): | |
| | c. Due to (or as e consequence of): | |
| | d. Due to (or as e consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnency | 23d. Deta of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal deeth 3☐Ectopic pregnency 4☐Pregnent et time of deeth 5☐Other (specify) 9☐Unknown | |

Part II. **Dther significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

| 23e. Did tobecco use contribute to the cause of death? | 24a. Was en autopsy performed? | 24b. Were autopsy findings availeble prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☒No 3☐Probebly 4☐Unknown | 1☒Yes 2☐No | 1☒Yes 2☐No |

| 25. Wes cese referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☒Yes 2☐No | Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☐Neturel 2☒Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | 3/12/01 | 7:45 PM | 1☐Yes 2☒No | Driver of Motor Vehicle Impacts Fixed Objects |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Street | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) Fort Ashby, West Virginia |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and menner es steted.
2☒ **Medical Examinar:** On the besis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to tha cause(s) and menner stated.

| 29b. Signature and title of certifier | 29c. Licanse number | 29d. Date signed (Month, Day, Yeer) |
|---|---|---|
| ▶ J Pettaner M.D. | O.C.M.E. | March 13, 2001 |

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)
Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 14 2001 | ▶ D Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

MD

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 09109

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Victor Eugene Dorsey
2. Date of Death: Month 3 Day 09 Year 01
3. Time of Death: 18:23
4a. Facility Name (If not institution, give street and number): Dorchester General Hospital
4b. City, Town, or Location of Death: CAMBRIDGE
4c. County of Death: Dorchester

**Funeral Director**

5. Social Security Number: 218-58-2254
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 46 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOV. 28, 1954
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Dorchester
10c. City, Town or Location: Cambridge
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 510 Muir Street
10f. Zip Code: 21613
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces?: 1 ☐ Yes 2 ☑ No. If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Production Worker
16b. Kind of Business/Industry: Frozen Foods Industry
17. Father's Name (First, Middle, Last): Victor Bennett Dorsey
18. Mother's Name (First, Middle, Maiden Surname): Leothia M. Stubbs
19a. Informant's Name/Relationship (Type, Print): Leon Dorsey
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4410 Maple Dam Road Cambridge, Maryland 21613
20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bethel Cemetery
Date: 3/16/2001
20c. Location - City or Town, State: Cambridge, Maryland
21. Signature of Funeral Service Licensee: Janelle C. Henry
22. Name and Address of Facility: Henry Funeral Home P.A. 510 Washington Street Cambridge, Maryland 21613

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | RENAL FAILURE | 2 wks |
| Due to (or as a consequence of): b. | LIVER FAILURE | 4 months |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last. Due to (or as a consequence of): c. | Alcoholism | 20 yrs |
| Due to (or as a consequence of): d. | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Pneumonia

Hyper AMMONIAEMIA

UTI

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA. Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Timothy J. Sniezek
29c. License number: D53253 MD
29d. Date signed (Month, Day, Year): 03/09/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Timothy J. Sniezek MD
503 A MUIR ST Cambridge, MD 21613

**State Registrar**

31. Date filed (Month, Day, Year): MAR 13 2001
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To be Completed by Funeral Director**

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 09110

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Ray Watson DeHart

2. Date of Death Month / Day / Year: March 12, 2001

3. Time of Death: 8:00 P. M.

4a. Facility Name *(If not institution, give street and number)*: 6 Warfield Place

4b. City, Town, or Location of Death: LaVale

4c. County of Death: Allegany

**Funeral Director**

5. Social Security Number: 220-10-3099

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 14, 1918

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Allegany

10c. City, Town or Location: LaVale

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 6 Warfield Place

10f. Zip Code: 21502

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Owner/Operator

16b. Kind of Business/Industry: Office Equipment

17. Father's Name *(First, Middle, Last)*: Erie H. DeHart

18. Mother's Name *(First, Middle, Maiden Surname)*: Credie A. (Price)

19a. Informent's Name/Relationship *(Type, Print)*: Nidine T. DeHart/ Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6 Warfield Place, LaVale, MD 21502

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Smithsburg Crematorium

Date: 3/13/01

20c. Location - City or Town, State: Smithsburg, MD

21. Signature of Funeral Service Licensee: William Kight

22. Name and Address of Facility: Kight Funeral Home 309-311 Decatur St., Cumberland, MD 21502

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Endstage Colon Carcinoma — One year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: G Wagoner MD

29c. License number: D22181

29d. Date signed *(Month, Day, Year)*: MARCH 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 925 Gary L. Wagoner, M. D. 925 Bishop Walsh Dr, Cumberland, MD 21502

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 14 2001

32. Registrar's Signature: Bonnie B Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

5

MDS

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09111

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Gean M. Davis

2. Date of Death (Month, Day, Year): 03 12 2001

3. Time of Death: 1:45 A.M.

4a. Facility Name (If not institution, give street and number): Moran Manor Nursing Home

4b. City, Town, or Location of Death: Westernport

4c. County of Death: Alleg.

**Funeral Director**

5. Social Security Number: 219-14-7232

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 07-08-1925

9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD.

10b. County: Alleg.

10c. City, Town or Location: Westernport

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 115 Johnson St.

10f. Zip Code: 21562

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): Ivor Bell

18. Mother's Name (First, Middle, Maiden Surname): Catherine Shillingburg

19a. Informant's Name/Relationship (Type, Print): Douglas Davis

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 115 Johnson St. Westernport, MD. 21562

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): St. Peter's Cem.

Date: 03-14-2001

20c. Location - City or Town, State: Westernport, MD

21. Signature of Funeral Service Licensee: ▶ Wm H Bullock

22. Name and Address of Facility: Fredlock Funeral Home 31 Jones St. Piedmont, WV.

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic carcinoma of left Breast — 22 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Amyotrophic Lateral Sclerosis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶

29c. License number: 22124

29d. Date signed (Month, Day, Year): 3/13/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jesus Tan, M. D., Frostburg Plaza, Frostburg, Maryland 21532

**State Registrar**

31. Date filed (Month, Day, Year): MAR 16 2001

32. Registrar's Signature: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0020**

permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

3

MD

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 09112

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): MARY VIRGINIA ENSOR

2. Date of Death (Month, Day, Year): March 6, 2001

3. Time of Death: 3:29 PM

4a. Facility Name (If not institution, give street and number): 3109 White Hall Road

4b. City, Town, or Location of Death: White Hall

4c. County of Death: Harford

**Funeral Director**

5. Social Security Number: 219-20-5457

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 12/5/1926

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD.

10b. County: Harford

10c. City, Town or Location: White Hall

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3109 White Hall Road

10f. Zip Code: 21161

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Bleck, White, etc. Specify: Caucasian

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Off Line Packer

16b. Kind of Business/Industry: Microbiology Laboratory

17. Father's Name (First, Middle, Last): Henry Clinton Jones Sr.

18. Mother's Name (First, Middle, Maiden Surname): Phoebe Leona Pierce

19a. Informant's Neme/Relationship (Type, Print): Stanley E. Ensor /Husband

19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): same as #10 a,b,c,e,f

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other (Specify)

20b. Piece of Disposition (Name of cemetery, crematory or other place): Carroll Cremation

Date: 3/8/2001

20c. Location - City or Town, State: Hampstead, Maryland

21. Signature of Funeral Service Licensee: M. Gladden Kurtz III

22. Name end Address of Facility: E.G. Kurtz & Son Funeral Home, P.A. Jarrettsville, Maryland

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complicetions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arreat, shock, or heart feilure. List only one ceuse on each line.

Approximete Interval Between Onset and Deeth

Immediete Cause (Finel disease or condition resulting in death): a. METASTATIC CARCINOMA

Due to (or es a consequence of): UNKNOWN PRIMARY

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury thet initiated events resulting In death) Lest

b. Due to (or as e consequenca of):

c. Due to (or as e consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: COPD, CoR pulmonale

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residenca 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, ferm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ Certifying Phyaician: To the best of my knowledge, deeth occurred at the time, date and pleca, end due to the cause(a) end manner as stated. 2☐ Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: M. Escalante MD

29c. License number: D17679

29d. Date signed (Month, Day, Year): 03/08/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): AGATON H. ESCALANTE, M.D. 3805 NORRISVILLE RD JARRETTSVILLE, MD 21084

**State Registrar**

31. Date filed (Month, Day, Year): MAR 9 - 2001

32. Registrar's Signeture: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 09113

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Rozier Wayne Embrey | March 18, 2001 | 0926 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Laurel Regional Hospital | Laurel | Prince George's |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-28-7003 | 1 X M 2 F | 70 Yrs. | | | Feb. 18, 1931 | Virginia |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Howard | Laurel | 1 Yes 2 X No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 9105 Blues Alley #H | 20723 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 Never Married 2 X Married 3 Widowed 4 Divorced | 1 Yes 2 X No If Yes, Give Year or Dates: | 1 Yes 2 X No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 9 | Ø | Clerk | Giant Food Store |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Rozier O. Embrey | Maggie Gray |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Gloria J. Embrey/Wife | 9105 Blues Alley #H, Laurel, MD 20723 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 Burial 2 X Cremation 3 Removal from State 4 Donetion 5 Other (Specify) | Metro Crematory, Inc. | March 20, 2001 | Catonsville, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| M00773 | Donaldson Funerl Home, P.A. 313 Talbott Avenue, Laurel, MD 20707 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

| | | |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Cardiac Arrest (Asystole) | 5 Minutes |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. Coronary Artery Disease | 20 Years |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnency | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 Yes 2 No 9 Unknown | 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Abdominal Pain

Alcoholism

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1 X Yes 2 No 3 Probably 4 Unknown | 1 Yes 2 X No | 1 Yes 2 X No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 Yes 2 X No | Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA | Other: 4 Nursing Home 5 Residence 8 Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Yeer) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 X Netural 2 Accident 3 Suicide 4 Homicide 5 Pending investigetion 6 Could not be determined | | M | 1 Yes 2 No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29e. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Yeer) |
|---|---|---|
| Timothy P. McClain MD | D39532 | March 19, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Timothy McClain, MD 321 Prince George Street, Laurel, MD 20707

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 22 2001 | G. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification; To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

15

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09114

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): EULA A. ELLIFRITZ
2. Date of Death (Month, Day, Year): March 7 2001
3. Time of Death: 2:27 p.m.
4a. Facility Name (If not institution, give street and number): Moran Manor Nursing Home
4b. City, Town, or Location of Death: Westernport
4c. County of Death: Allegany

**Funeral Director**

5. Social Security Number: 235-70-3359
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 21,1924
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: WV
10b. County: Mineral
10c. City, Town or Location: New Creek
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: HC 75, Box 11
10f. Zip Code: 26743
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): J. Clarence Alt
18. Mother's Name (First, Middle, Maiden Surname): Bertha Ward

19a. Informant's Name/Relationship (Type, Print): Alice V. Vanscoy/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 3, Box 3328 Keyser, WV 26726

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): Thrush Cemetery
Date: March 10 2001
20c. Location - City or Town, State: Antioch, WV

21. Signature of Funeral Service Licensee: Brian L. Smith
22. Name and Address of Facility: Smith Funeral Home 85 S. Main Street Keyser, WV 26726

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiac Dysrhythmia — 20 minutes
Due to (or as a consequence of):
b. Coronary Artery Disease — 10 years
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Dementia ; Diabetes Milletus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D21244
29d. Date signed (Month, Day, Year): 3/9/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jesus Tan, M.D. Frostburg Plaza Frostburg, MD 21532

**State Registrar**

31. Date filed (Month, Day, Year): MAR 15 2001
32. Registrar's Signature: Barbara B Sparks

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

4
4/25

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09115

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Raymond Salvatore Fusco, Sr.

2. Date of Death (Month, Day, Year): March 8, 2001

3. Time of Death: 10:50 PM

4a. Facility Name (If not institution, give street and number): 5610 Allender Road

4b. City, Town, or Location of Death: White Marsh

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 212-42-2461

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 58 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 22, 1942

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: White Marsh

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 5610 Allender Road

10f. Zip Code: 21162

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th Grade

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cable Splicer

16b. Kind of Business/Industry: Public Utility

17. Father's Name (First, Middle, Last): Salvatore Fusco

18. Mother's Name (First, Middle, Maiden Surname): Anne Hilda Wisniewski

19a. Informant's Name/Relationship (Type, Print): Mrs. Margaret L. Fusco (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5610 Allender Road, White Marsh, MD 21162

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Bayview Crematory

Date: 3/12/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Brian A. Wilkens

22. Name and Address of Facility: Schimunek Funeral Home, Inc. 9705 Belair Rd., BAltimore, MD 21236

**Physician /Medical Examiner**

23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. MULTIPLE MYELOMA — 2 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC RENAL FAILURE

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury: M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Date of Injury (Month, Day Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D31189

29d. Date signed (Month, Day, Year): MARCH 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MICHAEL J. MININSOHN, MD, 8813 WALTHAM WOODS RD, BALTIMORE, MD

**State Registrar**

31. Date filed (Month, Day, Year): MAR 12 2001

32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 09116

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Clara Mae Foreman

2. Date of Death (Month, Day, Year): Mar 10, 2001

3. Time of Death: 02:45pm

4a. Facility Name *(If not institution, give street and number)*: 1018 Lexington Avenue

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

**Funeral Director**

5. Social Security Number: 215-26-6376

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 71 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Mar 17, 1929

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: Allegany

10c. City, Town or Location: Cumberland

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1018 Lexington Avenue

10f. Zip Code: 21502

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify*: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: John W. Kennedy

18. Mother's Name *(First, Middle, Maiden Surname)*: Emma F Trail

19a. Informant's Name/Relationship *(Type, Print)*: Willis E. Foreman husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1018 Lexington Avenue;Cumberland, MD21502

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Hillcrest Memorial Par

Date: 3/13/2001

20c. Location - City or Town, State: Cumberland, MD

21. Signature of Funeral Service Licensee: Nicholas J. Scarpelli

22. Name and Address of Facility: Scarpelli Funeral Home P.A. Cumberland, Maryland 21502

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARCINOMA OF THE LUNG — 4 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: diabetic renal disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☑ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Donald F. Manger

29c. License number: D09231

29d. Date signed *(Month, Day, Year)*: Mar 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Donald F. Manger M.D. 11600 Bedford Road NE. Cumberland MD 21502

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 13 2001

32. Registrar's Signature: Emma G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

6

Yes

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 09117

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Louise C. Fletcher

2. Date of Death Month: March Day: 17, Year: 2001

3. Time of Death: 11:00 am

4e. Facility Name *(If not institution, give street and number)*: 5320 Dorsey Hall Dr. Apt. 414

4b. City, Town, or Location of Death: Ellicott City

4c. County of Death: Howard

**Funeral Director**

5. Social Security Number: 380-14-4423

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct. 26, 1921

9. Birthplace *(State or Foreign Country)*: Indiana

Usual Residence of Decedent

10e. State: Maryland

10b. County: Howard

10c. City, Town or Location: Ellicott City

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 5320 Dorsey Hall Dr.

10f. Zip Code: 21042

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12; College (1-4or 5+):

16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Edward Caldwell

18. Mother's Name *(First, Middle, Maiden Surneme)*: Mary Lee Weatherbee

19e. Informent's Neme/Reletionship *(Type, Print)*: Ellen Lusko / daughter

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 5253 Lightfoot Path Columbia, MD. 21044

20e. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Ptece of Disposition *(Neme of cemetery, cremetory or other piece)*: Metro Crematory

Date: Mar. 19 2001

20c. Location - City or Town, State: Catonsville, MD.

21. Signature of Funerel Service Licensee: [signature] Melogle

22. Name and Address of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD. 21043

**Physician /Medical Examiner**

23a. Pert1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediete Ceuse (Final diseese or condition resulting in deeth)

e. Myocardial Infarction — 1 hour

Due to (or es e consequence of):

Sequentielly tist conditions, if eny, teeding to immediete cause. Enter Underlying Ceuse (Dtsease or injury thet initiated events resulting in deeth) Lest

b. Coronary Artery Disease — 10 years

Due to (or es e consequenca of):

c.

Due to (or es e consequenca of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco uae contribute to the ceuse of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Was en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings aveileble prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Coutd not be determined

28e. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end piece, and due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) end menner stated.

29b. Signeture end title of certifier: Rita E. King MD

29c. License number: D0037155

29d. Dete signed *(Month, Day, Year)*: March 19, 2001

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Rita E. King, M.D. 11085 Little Patuxent Pkwy. Columbia, MD. 21044

**State Registrar**

31. Dete filed *(Month, Dey, Yeer)*: MAR 19 2001

32. Registrer's Signeture: Donna G. Sparks

DHMH 16 Rev 6/95

---

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(5)

cgf

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No: 2001 09118

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Rex Cecil Hankins

2. Date of Death Month Day Year: March 7, 2001

3. Time of Death: 1:10a.m.

4e. Facility Name *(If not institution, give street and number)*: 5128 Fawn Grove Road

4b. City, Town, or Location of Death: Pylesville

4c. County of Death: Harford

**Funeral Director**

5. Social Security Number: 213-14-4014

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 87 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 22,1913

9. Birthplace *(State or Foreign Country)*: Virginia

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD

10b. County: Harford

10c. City, Town or Location: Pylesville

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 5128 Fawn Grove Road

10f. Zip Code: 21132

10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Wes Decedant Ever in U.S. Armed Forces? 1☐Yas 2☒No If Yes, Give Yeer or Detas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American indian, Black, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highest grada completed)*: Elementary/Secondary (0-12): 8; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Carpenter

16b. Kind of Business/Industry: Industrial

17. Fathar's Name *(First, Middle, Last)*: Alexander W. Hankins

18. Mother's Nema *(First, Middle, Melden Surname)*: Rose Linkous

19e. Informant's Name/Relationship *(Type, Print)*: Daughter/Virginia Onion

19b. Malling Address *(Street end Number or Rurel Route Number, City or Town, State, Zip Code)*: 3721 Salem Church Road, Jarrettsville,MD 21084

20e. Method of Disposition: 1☐Buriel 2☒Cremation 3☒Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or othar piece)*: Yorktowne Casket Co. Cremation Service

Date: 3/8/01

20c. Location - City or Town, Stete: York, Pennsylvania

21. Signeture of Funeral Service Licensee:

22. Name and Address of Facility: J. J. Hartenstein Mortuary Inc., 19 S. Main St. Stewartstown, PA 17363

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the diseasa, or complications that caused the deeth. Do not antar the mode of dying, such es cardiac or raspiratory arrest, shock, or heert feilure. List only one cause on each line.

Approximeta Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in deeth) a. PANCREATIC CANCER — 3 MONTHS

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part ii. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part i.

23b. **Did tobacco use contributa to the cause of death?** 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Wes an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Wes case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☐inpatient 2☐ER/Outpatient 3☐DOA Othar: 4☐Nursing Home 5☒Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Neturei 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of injury *(Month, Day Year)*

28b. Time of injury M

28c. injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Piece of injury - At home, farm, streat, fectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, dete end piece, and due to tha cause(s) end mennar stated.

29b. Signature and title of certifier: J. Edwards MD

29c. License number: D31775

29d. Date signed *(Month, Day, Year)*: MARCH 7, 2001

30. Neme and address of person who completed ceuse of deeth (Item 23a) (Type, Print): JOAN P. EDWARDS, M.D. 2112 BELAIR ROAD FALLSTON, MARYLAND 21047

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 12 2001

32. Registrer's Signeture: D. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 09119

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Catherine C. Hughes

2. Date of Death Month: 03 Day: 08 Year: 2001

3. Time of Death: 03:50 am

4e. Facility Name *(If not institution, give street and number)*: Harford Memorial Hospital

4b. City, Town, or Location of Death: Havre de Grace

4c. County of Death: Harford

**Funeral Director**

5. Social Security Number: 220-03-6234

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 89 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 9/03/1911

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Harford

10c. City, Town or Location: Darlington

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3412 Hughes Road

10f. Zip Code: 21034

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married ☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry:

17. Father's Name *(First, Middle, Last)*: William Schumm

18. Mother's Name *(First, Middle, Maiden Surname)*: Anna Verona Herrmann

19a. Informant's Name/Relationship *(Type, Print)*: Ella MAe Laird- daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3413 Hughes Rd., Darlington, MD 21034

20a. Method of Disposition: 1☐ Burial ☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Eagle Evans Crematory

Date: 3/9/01

20c. Location - City or Town, State: Leola, PA

21. Signature of Funeral Service Licensee: Jeffrey P. Lavelidge

22. Name and Address of Facility: Harkins F.H. Inc., 600 MAin St., Delta, PA 17314

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Congestive Heart Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Pulmonary Hypertension

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Right lower lung pneumonia

Chronic Cholecystitis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D 0055722

29d. Date signed *(Month, Day, Year)*: 03/08/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Seong Chin , Union Ave., Havre de Grace, MD

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 12 2001

32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Hughes, Catherine

10

**Please Type or Print In Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 09120

**Physician /Medical Examiner** | **Funeral Director**

1. Decedent's Name (First, Middle, Last): Richard Kevin Horney
2. Date of Death (Month, Day, Year): March 1, 2001
3. Time of Death: 1300 M
4a. Facility Name (If not institution, give street and number): Kent & Queen Anne's Hospital, Inc.
4b. City, Town, or Location of Death: Chestertown
4c. County of Death: Kent
5. Social Security Number: 213-90-6360
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 36 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 10, 1964
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Queen Anne's
10c. City, Town or Location: Centreville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 710 Hayden Road
10f. Zip Code: 21617
10g. Citizen of What Country?: USA
11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Maintenance Worker
16b. Kind of Business/Industry: Queen Anne's County Road Dept.
17. Father's Name (First, Middle, Last): Calvin Grason Horney, Jr.
18. Mother's Name (First, Middle, Maiden Surname): Ellen Hoxter
19a. Informant's Name/Relationship (Type, Print): C. Grason Horney, Jr./Father
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 710 Hayden Road, Centreville, MD 21617
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Stevensville Cemetery
Date: 3/7/2001
20c. Location - City or Town, State: Stevensville, Maryland
21. Signature of Funeral Service Licensee: ▶ JOHN B. MERCERON CFSP
22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 408 S. Liberty St., Centreville, MD 21617

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errast, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Ventricular Fibrillation — Approximate Interval Between Onset and Death: 15 min
Due to (or as a consequence of):
b. Dilated Cardiomyopathy — 1 month
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivary Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Pulmonary Embolus; Chemical Hepatitis. Deep Vein Thrombosis Renal Failure.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No
25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
28. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ George M Young MD
29c. License number: D31979
29d. Date signed (Month, Day, Year): March 2, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GEORGE M. YOUNG 100 BROWN ST, CHESTERTOWN, MD 21620

**State Registrar**

31. Date filed (Month, Day, Year): MAR 0 6 2001
32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09121

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Loretta Hogan

2. Data of Death — Month: March Day: 20 Year: 2001

3. Time of Death: 9:15 AM

4a. Facility Name (If not institution, give street and number): Brooke Grove Nursing Home

4b. City, Town, or Location of Death: Sandy Spring

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 469-01-6139

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 86 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 24, 1914

9. Birthplace (State or Foreign Country): Minnesota

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Highland

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 13507 Villa D'Est Drive

10f. Zip Code: 20777

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 — College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerical Worker

16b. Kind of Business/Industry: Hospital

17. Father's Name (First, Middle, Last): Fred J. Gebro

18. Mother's Name (First, Middle, Meiden Surname): Theresa Petries

19a. Informant's Name/Relationship (Type, Print): Kathleen D'Agrosa / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13507 Villa D'Est Drive Highland, Maryland 20777

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory — Date: 3/22/01

20c. Location - City or Town, State: Catonsville, Maryland

21. Signature of Funeral Service Licensee: [signature] 1001142

22. Name and Address of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. cerebrovascular accident

Due to (or as a consequence of):
b. hypertension

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. coronary artery disease

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.

29c. License number: D52481

29d. Date signed (Month, Day, Year): March 20 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): David Plotkin M.D. 18111 Prince Philip Drive, Olney, MD 20832

**State Registrar**

31. Date filed (Month, Day, Year): MAR 22 2001

32. Registrar's Signature: [signature] B. Sparks

DHMH 16 Rev 6/95

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(10)

Cof

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09122

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): DONALD E.B. HOLTZMAN

2. Date of Death (Month, Day, Year): MARCH 9 2001

3. Time of Death: 8:40 AM

4a. Facility Name (If not institution, give street and number): CUMBERLAND NURSING HOME

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

**Funeral Director**

5. Social Security Number: 217-10-4041

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): OCT 30, 1916

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ALLEGANY

10c. City, Town or Location: CUMBERLAND

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 14806 N. BEL AIR DRIVE

10f. Zip Code: 21502

10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No. If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ELEMENTARY SCHOOL TEACHER

16b. Kind of Business/Industry: EDUCATION

17. Father's Name (First, Middle, Last): EDGAR HOLTZMAN

18. Mother's Name (First, Middle, Maiden Surname): CARRIE WILSON

19a. Informent's Name/Relationship (Type, Print): LEONARD HOLTZMAN-BROTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14806 N. BEL AIR DR., CUMBERLAND, MD 21502

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): SUNSET MEMORIAL PARK

Date: MARCH 12, 2001

20c. Location - City or Town, State: CUMBERLAND, MD

21. Signature of Funeral Service Licensee: Douglas L Hafer

22. Name and Address of Facility: HAFER CHAPEL OF THE HILLS MORTUARY, 1302 NATIONAL HWY, LAVALE, MD 21502

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Probable Coronary artery Disease — 5yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I: Dementia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [X] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D0033280

29d. Date signed (Month, Day, Year): March 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. S. GUPTA, 625 KENT AVE., CUMBERLAND, MD 21502

**State Registrar**

31. Date filed (Month, Day, Year): MAR 12 2001

32. Registrar's Signature: Deanna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Amended #16a, nls, 3/9/01, Allegany Co.

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09123

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Mary Lee Jacopi
2. Date of Death (Month, Day, Year): March 8, 2001
3. Time of Death: 0130 AM
4a. Facility Name (If not institution, give street and number): Copper Ridge Nursing Home
4b. City, Town, or Location of Death: Sykesville
4c. County of Death: Carroll

**Funeral Director**

5. Social Security Number: 215-14-6291
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 80 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 23, 1920
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Allegany
10c. City, Town or Location: Cumberland
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1810 Frederick St.
10f. Zip Code: 21502
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ~~technician~~ technician
16b. Kind of Business/Industry: medical

17. Father's Name (First, Middle, Last): William J. Neubeiser
18. Mother's Name (First, Middle, Maiden Surname): Mary Catherine Lippold

19a. Informant's Name/Relationship (Type, Print): Robert Neubeiser (nephew)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10812 Long Meadow Dr. Damascus, MD 20872

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): S.S. Peter & Paul Cemt. — Date: 3/10/01
20c. Location - City or Town, State: Cumberland, MD

21. Signature of Funeral Service Licensee: Robert C. Adams
22. Name and Address of Facility: Merritt-Adams Funeral Home, P.A. 404 Decatur St. Cumberland, MD 21502

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Alzheimers Dementia — 5 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 8☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robert L. Moss, MD
29c. License number: 032882
29d. Date signed (Month, Day, Year): 3/8/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert L. Moss, MD 114 Business Center Drive Reisterstown, Maryland

**State Registrar**

31. Date filed (Month, Day, Year): MAR 09 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

25

MD

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09124

KELLY, JOHN J.

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): John C. Kelly

2. Date of Death: Month March, Day 07, Year 2001

3. Time of Death: 3:30 P.M.

4a. Facility Name (If not institution, give street and number): VAMHCS FORT HOWARD DIVISION

4b. City, Town, or Location of Death: FORT HOWARD

4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 212-12-4475

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): Dec. 1, 1921

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 524 North Charles St., Apt. 1314

10f. Zip Code: 21201

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th Grade; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mutual Clerk

16b. Kind of Business/Industry: Gambling

17. Father's Name (First, Middle, Last): Thomas Patrick Kelly, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Mary Margaret Wess

19a. Informent's Name/Relationship (Type, Print): Mr. John J. Kelly (nephew)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 818 Flintlock Drive, Bel Air, MD 21015

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery

Date: 3/10/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Mabel Taylor

22. Name and Address of Facility: Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. LUNG CANCER WITH METASTASIS — one year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Aurora C. Tan, M.D.

29c. License number: D 14958

29d. Date signed (Month, Day, Year): 03-07-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): AURORA C. TAN, M.D. 9600 NORTH POINT ROAD, FORT HOWARD, MD 21052

**State Registrar**

31. Date filed (Month, Day, Year): MAR 8 - 2001

32. Registrar's Signature: [signature]

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DEC 9 2021

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 09125

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Rosalie Kim

2. Date of Death (Month, Day, Year): March 14, 2001

3. Time of Death: 6:15 am

4e. Facility Name *(If not Institution, give street and number)*: Genesis Health Care

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 136-14-5450

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 91 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept 26, 1909

9. Birthplace *(State or Foreign Country)*: Georgia

Usual Residence of Decedent

10a. State: Md.

10b. County: Anne Arundel

10c. City, Town or Location: Pasadena

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 1580 Marco Drive

10f. Zip Code: 21122

10g. Citizen of What Country?: U.S.A.

11. Maritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12) / College (1-4or 5+): 4 years

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: School Teacher

16b. Kind of Business/Industry: P.G. County Schools

17. Father's Name *(First, Middle, Last)*: Elijah Coates Fincannon

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Trotter

19e. Informant's Name/Relationship *(Type, Print)*: Boris Kim / son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1580 Marco Drive Pasadena, Maryland 21122

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Emmanuel Church Cemetery

Date: Mar. 17, 2001

20c. Location - City or Town, Stete: Scaggsville, Maryland

21. Signature of Funeral Service Licensee: Donaldson M00160

22. Name end Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, Maryland 20707

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)

a. Failure to Thrive — 2 weeks

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Severe peripheral vascular disease — years

Due to (or as a consequenca of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco uea contributa to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: 8V0294

29d. Date aigned *(Month, Day, Year)*: March 15, 2001

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): 2108 DiDonato Drive, Chester, Maryland

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 19 2001

32. Registrar's Signature: Sandra G. Sparks

DHMH 16 Rev 6/95

**Baltimore, Maryland 21215-0020**

permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires thet the death certificete be executed within 24 hours efter death.
**To the Funeral Director:** After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

(20)

CJJ

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 09126

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| URSULA L. KUHLMAN | March 4, 2001 | 10:45 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| SACRED HEART HOSPITAL | CUMBERLAND | ALLEGANY |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-68-5925 | 1☐M 2☒F | 89 Yrs. | | | NOV.8,1911 | MARYLAND |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | ALLEGANY | LAVALE | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 24 MARTZ LANE | 21502 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8 | | HOMEMAKER | HOME |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| MARTIN JOSEPH MARTZ | ELIZABETH MARY MARLEY |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| URSULA JOAN WHITMAN/DAUGHTER | 20001 W. FLINTSTONE CREEK RD., FLINTSTONE, MD 21530 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | SS. PETER & PAUL CEM. | 03/09/2001 | CUMBERLAND, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Wendy D. Upchurch | UPCHURCH FUNERAL HOME, P.A. 202 GREENE STREET, CUMBERLAND, MD 21502 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Cerebrovascular Accident | 1 week |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): Coronary Artery Disease | 3 months |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| If FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ | D36766 | March 5, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Vikramaditya Poonai M.D. 924 Seton Drive Cumberland MD 21502

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 07 2001 | |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09127

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: MARTHA ESTELLE KESECKER

2. Date of Death — Month: MARCH Day: 15 Year: 2001

3. Time of Death: 14:15

4a. Facility Name *(If not institution, give street and number)*: MEMORIAL HOSPITAL & MEDICAL CENTER

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

**Funeral Director**

5. Social Security Number: 215-42-4842

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 92 Yrs.

If Under 1 Year — Months: Days: If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: JUNE 2 1908

9. Birthplace *(State or Foreign Country)*: W.VA.

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ALLEGANY

10c. City, Town or Location: CUMBERLAND

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 519 PATTERSON AVENUE

10f. Zip Code: 21502

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOME MAKER

16b. Kind of Business/Industry: HOME MAKER

17. Father's Name *(First, Middle, Last)*: CLARENCE FEARNOW

18. Mother's Name *(First, Middle, Maiden Surname)*: IRENE REAM

19a. Informant's Name/Relationship *(Type, Print)*: HARRY G. KESECKER SON

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1465 LUDWICK STREET KEYSER, W.VA. 26726

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: CUMBERLAND CREMATORY Date: MARCH 16, 2001

20c. Location - City or Town, State: CUMBERLAND MD.

21. Signature of Funeral Service Licensee: ▶ Wade L. Merritt

22. Name and Address of Facility: MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular Accident — days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Diabetes Mellitus — years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypertention, Obesity

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Beverly McCalkins MD

29c. License number: D0054411

29d. Date signed *(Month, Day, Year)*: MARCH 15 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. BEVERLY CALKINS, MEMORIAL HOSPITAL MEDICAL BLDG., CUMBERLAND, MD 21502

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 16 2001

32. Registrar's Signature: ▶ Joanne G Sparks

DHMH 16 Rev 6/95

ORIGINAL

MARTHA KESECKER 215-42-4842

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death* Reg. No. 2001 09128

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: CLARK WEBSTER LEDNUM
2. Date of Death Month / Day / Year: Feb. 26, 2001
3. Time of Death: 1935
4a. Facility Name *(If not institution, give street and number)*: The Memorial Hospital
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

**Funeral Director**

5. Social Security Number: 219-07-5786
6. Sex: [X] 1 M [ ] 2 F
7. Age *(In yrs. last birthday)*: 83 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Nov. 3, 1917
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Talbot
10c. City, Town or Location: Easton
10d. Inside City Limits: [X] 1 Yes [ ] 2 No
10e. Street and Number: 1070 N. Washington St.
10f. Zip Code: 21601
10g. Citizen of What Country?: U.S.A.
11. Marital Status: [ ] 1 Never Married [ ] 2 Married [X] 3 Widowed [ ] 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? [X] 1 Yes [ ] 2 No — If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) [ ] 1 Yes [X] 2 No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): 10 — College (1-4 or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Boatbuilder-Waterman
16b. Kind of Business/Industry: Seafood
17. Father's Name *(First, Middle, Last)*: Ira Lednum
18. Mother's Name *(First, Middle, Maiden Surname)*: Esta May Frampton
19a. Informant's Name/Relationship *(Type, Print)*: Clark R. Lednum Stepson
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O. Box 764 Cleelum, Washington 98943
20a. Method of Disposition: [ ] 1 Burial [X] 2 Cremation [ ] 3 Removal from State [ ] 4 Donation [ ] 5 Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Capitol Crematory
Date: Feb. 27, 2001
20c. Location - City or Town, State: Dover, Delaware
21. Signature of Funeral Service Licensee: Harrison E Leonard
22. Name and Address of Facility: Harrison E. Leonard Funeral Home, 312 S. Talbot St. St, Michaels, Maryland 21663

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Cardiogenic shock | hours |
| Due to (or as a consequence of): b. | Acute Myocardial infarction | hours |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c. | Pneumonia | hours |
| Due to (or as a consequence of): d. | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Parkinsonism

23b. Did tobacco use contribute to the cause of death? [ ] 1 Yes [ ] 2 No [X] 3 Probably [ ] 4 Unknown

24a. Was an autopsy performed? [ ] 1 Yes [X] 2 No

24b. Were autopsy findings available prior to completion of cause of death? [ ] 1 Yes [ ] 2 No

25. Was case referred to medical examiner? [ ] 1 Yes [X] 2 No

26. Place of Death *(Check only one)*: Hospital: [ ] 1 Inpatient [X] 2 ER/Outpatient [ ] 3 DOA — Other: [ ] 4 Nursing Home [ ] 5 Residence [ ] 8 Other *(Specify)*

27. Manner of Death: [X] 1 Natural [ ] 2 Accident [ ] 3 Suicide [ ] 4 Homicide [ ] 5 Pending investigation [ ] 6 Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? [ ] 1 Yes [ ] 2 No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: [X] 1 **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. [ ] 2 **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D25933
29d. Date signed *(Month, Day, Year)*: 2.27.01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael D. Crowley M.D. 508 Idlewild Ave. Easton, Maryland 21601

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 0 5 2001
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

Clark Lednum

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09129

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Edna LeBlanc

2. Date of Death (Month, Day, Year): March 9, 2001

3. Time of Death: 0600

4e. Facility Name (If not institution, give street and number): Mallard Bay Nursing & Rehabilitation Center

4b. City, Town, or Location of Death: Cambridge

4c. County of Death: Dorchester

**Funeral Director**

5. Social Security Number: 058-01-2932

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 96 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 3, 1904

9. Birthplace (State or Foreign Country): New York

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland

10b. County: Dorchester

10c. City, Town or Location: Cambridge

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 107 Oakley Street

10f. Zip Code: 21613

10g. Citizen of What Country? USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Manager

16b. Kind of Business/Industry: Insurance

17. Father's Name (First, Middle, Last): William LeBlanc

18. Mother's Name (First, Middle, Maiden Surname): Rosina

19a. Informant's Name/Relationship (Type, Print): Sydney LeBlanc Good/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 107 Oakley St., Cambridge, MD 21613

20a. Method of Disposition: 1☒ Burial 2☒ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Moravian Cemetery | Date: 3-20-01

20c. Location - City or Town, State: Staten Island, NY

21. Signature of Funeral Service Licensee: Colleen Curran-Bromwell

22. Name and Address of Facility: Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD 21613

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Cardiac Arrhythmia | 4 minutes |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | b. Multi Infarct Dementia | 10 years |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Debilitation

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael Fadden

29c. License number: D26384

29d. Date signed (Month, Day, Year): March 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael Fadden M.D. 302 Collins Ave Hurlock, MD 21643

**State Registrar**

31. Date filed (Month, Day, Year): MAR 13 2001

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Amended # 2
3/7/01, Allegany Co. MLU

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No: 2001 09130

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| Margaret | Mary | Lynch | March | 02 ~~1~~, | 2001 | 05:30 a M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Sacred Heart Hospital | Cumberland | Allegany |

**Funeral Director**

| 5. Social Security Number | 8. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 214-07-6023 | 1☐ M 2☒ F | 83 Yrs. | | | | | Dec 5, 1917 | MD |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Allegany | Cumberland | X☐ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 308 Vine Place | 21502 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married X☐ Widowed 4☐ Divorced | 1☐ Yes X☐ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| John Briner | Frances (Grabenstein) |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mary Frances Lynch Daughter | 308 Vine Place; Cumberland, MD 21502 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | St. Mary's Cemetery | 3/05/ 2001 | Cumberland, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Nicholas J. Scarpelli | Scarpelli Funeral Home P.A. Cumberland, Maryland 21502 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Advanced Carcinoma Breast | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): | 1991 |
| | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☒ No |

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | | 1☐ Yes 2☐ No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| | D23371 | March 5, 2001 |

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)
Qamar U Zaman M.D. 625 Kent Avenue Cumberland MD 21502

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 07 2001 | |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

MU 6

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09131

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): JUDY ANN LINN

2. Date of Death (Month, Day, Year): March 9, 2001

3. Time of Death: 5:15 A.M.

4a. Facility Name (If not institution, give street and number): Memorial Hospital & Medical Center

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

**Funeral Director**

5. Social Security Number: 234-45-0024

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 50 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JUNE 22 1950

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ALLEGANY

10c. City, Town or Location: MT. SAVAGE

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 12900 WOODCOCK HOLLOW ROAD

10f. Zip Code: 21545

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOME MAKER

16b. Kind of Business/Industry: HOME MAKER

17. Father's Name (First, Middle, Last): THOMAS JOSEPH LINN

18. Mother's Name (First, Middle, Maiden Surname): OTHOLIA ALMA HAMILTON

19a. Informant's Name/Relationship (Type, Print): RONALD LINN BROTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12514 WOODCOCK HOLLOW ROAD MT. SAVAGE, MARYLAND 21545

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): REST LAWN CEMETERY MARCH

Date: 12 2001

20c. Location - City or Town, State: LAVALE, MARYLAND

21. Signature of Funeral Service Licensee: Dale L. Merritt

22. Name and Address of Facility: MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Melanoma with metastases — 2 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: R. Barrera

29c. License number: D0014865

29d. Date signed (Month, Day, Year): March 10th, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 500 Memorial Avenue, Suite 201 Dr. R. Barrera, Memorial Hospital Medical Building, Cumberland, MD 21502

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

JUDY LINN 214-07-5944

**State Registrar**

31. Date filed (Month, Day, Year): MAR 12 2001

32. Registrar's Signature: Donna B Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09132

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: TERRY LYNN LONG

2. Date of Death Month: March Day: 10, Year: 2001

3. Time of Death: 1610

4a. Facility Name *(If not institution, give street and number)*: SACRED HEART HOSPITAL

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 236-15-1120

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 42 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Mar. 25, 1958

9. Birthplace *(State or Foreign Country)*: WEST VIRGINIA

Usual Residence of Decedent

10a. State: WV

10b. County: MINERAL

10c. City, Town or Location: FORT ASHBY

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: DAN'S RUN ROAD

10f. Zip Code: 26719

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 0 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: NEVER WORKED

16b. Kind of Business/Industry: N/A

17. Father's Name *(First, Middle, Last)*: EARL LONG

18. Mother's Name *(First, Middle, Maiden Surname)*: ROSALEE VANCE

19a. Informant's Name/Relationship *(Type, Print)*: ROSALEE LONG / MOTHER

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: ROUTE 1, BOX 117 - BEVERLY, WV 26253

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: LITTLE ARLINGTON CEMETERY

Date: 03/13/2001

20c. Location - City or Town, State: ELKINS, WV

21. Signature of Funeral Service Licensee: Wendy D. Lockhart

22. Name and Address of Facility: UPCHURCH FUNERAL HOME, P.A. 202 GREENE STREET, CUMBERLAND, MD 21502

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Cardiorespiratory arrest | 1 hour |
| Due to (or as a consequence of): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. | Acute bronchitis | 1 week |
| Due to (or as a consequence of): | | |
| c. | | |
| Due to (or as a consequence of): | | |
| d. | | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Renal failure; Blindness

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: George Day, MD

29c. License number: D12532

29d. Date signed *(Month, Day, Year)*: March 10, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Box 912 Schell Drive Cumberland MD 21502

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 14 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

---

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

01-1410-001
crn
Johnny Lee Lambert, Jr.

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- State Registrar

*Certificate of Death*

Reg. No: 2001 09133

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| Johnny | Lee | Lambert Jr. | March | 12 | 2001 | 9:50 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Memorial Hospital | Cumberland | Allegany |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 236-25-8452 | 1 X M 2 F | 16 Yrs. | | | May 28, 1984 | MD |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| WV | Mineral | Ridgeley | 1 Yes 2 X No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 45 Potomac Street | 26753 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 X Never Married 2 Married 3 Widowed 4 Divorced | 1 Yes 2 X No If Yes, Give Year or Dates: | 1 Yas 2 X No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 10 | | student | high school |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Johnny Lee Lambert, Sr. | Linda D (Hapney) |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Johnny L. Lambert, Sr. father | 45 Potomac Street; Ridgeley WV 26753 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | Springfield Hill Cemet2001 | 3/15/ | Springfield, WV |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Nicholas J. Scarpelli | Scarpelli Funeral Home, P.A. Cumberland, MD 21502 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Multiple Injuries | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: b. | Due to (or as a consequence of): | |
| c. | Due to (or as a consequence of): | |
| d. | Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1 Yes 2 No 9 Unknown | 1 Liva birth 2 Fatal death 3 Ectopic pregnancy 4 Pregnant at tima of daath 5 Other (specify) _____ 9 Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yas 2 X No 3 Probably 4 Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| X 1 Yes 2 No | X 1 Yas 2 No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 X Yas 2 No | Hospital: 1 Inpatient 2 X ER/Outpatient 3 DOA | Other: 4 Nursing Home 5 Residence 6 Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 Natural 2 X Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | 3/12/01 | 1945 M | 1 Yas 2 X No | Passenger in vehicle accident |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
| | STREET | | | Dennison Hollow St. West Virginia Ft. Ashby |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. 2 X **Medical Examinar:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Data signed (Month, Day, Yaar) |
|---|---|---|
| [signature] | O.C.M.E. | March 13, 2001 |

30. Name and address of person who completed causa of death (Item 23a) (Typa, Print)

J. Lafon Locke, MD — 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 14 2001 | [signature] |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09134

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: GEORGENE REBA MINER
2. Date of Death Month / Day / Year: March 04, 2001
3. Time of Death: 1510
4a. Facility Name *(If not institution, give street and number)*: The Memorial Hospital
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

**Funeral Director**

5. Social Security Number: 440-18-9148
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 84 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: FEB 25, 1917
9. Birthplace *(State or Foreign Country)*: TEXAS

Usual Residence of Decedent

10a. State: MD
10b. County: TALBOT
10c. City, Town or Location: EASTON
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 501 DUTCHMANS LANE
10f. Zip Code: 21601
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: COMPUTER SPECIALIST
16b. Kind of Business/Industry: FEDERAL GOVERNMENT

17. Father's Name *(First, Middle, Last)*: GEORGE R. CROSS
18. Mother's Name *(First, Middle, Maiden Surname)*: ARA COMPTON

19a. Informent's Name/Relationship *(Type, Print)*: PATRICIA HOLMES/DAUGHTER
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 23860 MT. MISERY RD ST. MICHAELS, MD 21663

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: CHESAPEAKE CREMATION CTR
Date: 3-06-01
20c. Location - City or Town, State: STEVENSVILLE, MD

21. Signature of Funeral Service Licensee: ▶ Joseph M. Osfrowski
22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Myocardial Infarction (Probable)
Due to (or as a consequence of):
b. Sepsis
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Staff Physician MD
29c. License number: D 50328
29d. Date signed *(Month, Day, Year)*: March 5TH, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JAMES ELMORE M.D. 219 S WASHINGTON ST EASTON, MD 21601

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 0 6 2001
32. Registrar's Signature: ▶ Bessie G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Georgene Miner
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09135

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Ola Geneva McClellan
2. Date of Death (Month, Day, Year): March 11, 2001
3. Time of Death: 3:16 A.M.
4a. Facility Name (If not institution, give street and number): Harford Memorial Hospital
4b. City, Town, or Location of Death: Havre de Grace
4c. County of Death: Harford

**Funeral Director**

5. Social Security Number: 420-30-8932
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 76 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 3, 1925
9. Birthplace (State or Foreign Country): Alabama

Usual Residence of Decedent

10a. State: MD
10b. County: Harford
10c. City, Town or Location: Aberdeen
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 624 South Stepney Road
10f. Zip Code: 21001
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: In home

17. Father's Name (First, Middle, Last): Sam H. Dyer
18. Mother's Name (First, Middle, Maiden Surname): Fannie B. Gunter

19a. Informant's Name/Relationship (Type, Print): William J. McClellan, III (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 624 South Stepney Road, Aberdeen, MD 21001

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Grove Presbyterian Cem.
Date: 3/14/01
20c. Location - City or Town, State: Aberdeen, Maryland

21. Signature of Funeral Service Licensee: ▶ Kenneth B. Cargo
22. Name and Address of Facility: Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Interstitial Pneumonitis & pulmonary fibrosis — 10 days
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Chronic pulmonary Disease (obstructive)
Severe Rheumatoid arthritis
Congestive heart failure
Pleural effusion

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Mirza Abaig MD
29c. License number: D43115
29d. Date signed (Month, Day, Year): 3-11-01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 615 S. Union Avenue, Havre de Grace MD 21078

**State Registrar**

31. Date filed (Month, Day, Year): MAR 13 2001
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3/11/01 DR Baig
3/14/01 Aug
3164
McClellan, Ola
10

10:25 AM

Dolline V. Mixter 3/6/01

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 09136

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Dolline V. Mixter | March 6 2001 | 10:25 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Gilchrist Nursing Center | Baltimore | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-22-1141 | 1☐M 2☒F | 72 Yrs. | | | 3/28/1928 | Md. |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md. | Harford | Bel Air | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 103 Princeton Lane | 21014 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12th grade | | machine operator | Noxell |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| John T. Fletcher | Lillian A. Crawford Fletcher |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| John R. Mixter husband | 103 Princeton Lane Bel Air, Maryland 21014 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Meadowridge Mem. Pk. | 3/9/2001 | Elkridge, Md. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Mark T. Bosc | Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 21014 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | COPD | years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): b. | Alpha I Antitrypsin deficiency | years |
| Due to (or as a consequence of): c. | | |
| Due to (or as a consequence of): d. | | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnent at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) Hospice |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | D0051926 | March 6, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Helen M. Gordon MD 6565 N. Charles St Baltimore MD 21204

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 9 - 2001 | [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

---

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

12

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 09137

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): DOROTHY ELIZABETH MAHANEY
2. Date of Death (Month, Day, Year): MARCH 8 2001
3. Time of Death: 10:17 AM
4a. Facility Name (If not institution, give street and number): MAGNOLIA HALL
4b. City, Town, or Location of Death: CHESTERTOWN
4c. County of Death: KENT

**Funeral Director**

5. Social Security Number: 244-12-4601
8. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 82 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN. 4, 1919
9. Birthplace (State or Foreign Country): NORTH CAROLINA

Usual Residence of Decedent

10a. State: MD
10b. County: KENT
10c. City, Town or Location: CHESTERTOWN
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 101 MORGNEC ROAD
10f. Zip Code: 21620
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+): -0-
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): RAY VON SMITH
18. Mother's Name (First, Middle, Maiden Surname): LOTTIE BELL ADAMS

19a. Informant's Name/Relationship (Type, Print): FRANCIS MAHANEY / HUSBAND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 101 MORGNEC ROAD, APT. , CHESTERTOWN, MD 21620

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CHESTERFIELD CEMETERY
Date: 3-12-2001
20c. Location - City or Town, State: CENTREVILLE, MD

21. Signature of Funeral Service Licensee: Gary B. Fellows
22. Name and Address of Facility: FELLOWS, HELFENBIEN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart-failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia — 18 hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of): Severe End Stage Chronic Obstructive Pulmonary Disease
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnent at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Cor Pulmonale/CHF/Hx Tachycardia./Hx GI Bleed - Diverticular Disease/AAA Non Operable/Pelvic Mass HTN/Schizophrenia/Personality D/O/Gall Stones

23e. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown
24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the besis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D50996
29d. Date signed (Month, Day, Year): MARCH 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): NEIL STODDARD, M.D., 100 BROWN ST., CHESTERTOWN, MD 21620

**State Registrar**

31. Date filed (Month, Day, Year): MAR 12 2001
32. Registrar's Signature: [signature] G. Sparks

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 09138

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Karen Bramble Murphy

2. Date of Death Month / Day / Year: March 12 2001

3. Time of Death: 0845

4a. Facility Name *(If not institution, give street and number)*: 3535 Indian Grant Road

4b. City, Town, or Location of Death: East New Market

4c. County of Death: Dorchester

**Funeral Director**

5. Social Security Number: 219-46-4791

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 54 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov. 17 1946

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Dorchester

10c. City, Town or Location: East New Market

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3535 Indian Grant Road

10f. Zip Code: 21631

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 3

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: nurse

16b. Kind of Business/Industry: state hospital

17. Father's Name *(First, Middle, Last)*: Philip Lybrand Bramble

18. Mother's Name *(First, Middle, Maiden Surname)*: Louise Pritchett

19a. Informant's Name/Relationship *(Type, Print)*: Crawford G. Murphy - son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5245 Ferry Creek Lane, Acworth, GA 30102

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Old Trinity Churchyard — Date: 3-16

20c. Location - City or Town, State: Church Creek, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Thomas Funeral Home, P.A. 700 Locust St., Cambridge, MD 21613

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Arrhythmia — Approximate Interval: 4 min

Due to (or as a consequence of):

b. Congestive Heart Failure — Approximate Interval: 3 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Hypertension — Approximate Interval: 5 yrs

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D26388

29d. Date signed *(Month, Day, Year)*: March 13 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael Fackler MD 302 Collins Ave Hurlock MD. 21643

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 14 2001

32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

**To Be Completed by Funeral Director**

fds

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No: 2001 09139

3/8/01 8:15AM

Edwin A. Murphy Resp. ceased Lds

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Physician /Medical Examiner**

**Funeral Director**

**To Be Completed by Funeral Director**

| | | | | |
|---|---|---|---|---|
| 1. Decedent's Name (First, Middle, Last): EDWIN ALLEN MURPHY | | | 2. Date of Death: Month MARCH, Day 8, Year 2001 | 3. Time of Death: 8:15AM |
| 4a. Facility Name (If not institution, give street and number): GLASGOW NURSING HOME | 4b. City, Town, or Location of Death: CAMBRIDGE | 4c. County of Death: DORCHESTER | | |
| 5. Social Security Number: 218-09-3143 | 6. Sex: 1 [X] M 2 [ ] F | 7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year): APRIL 11, 1911 | 9. Birthplace (State or Foreign Country): MARYLAND |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | DORCHESTER | VIENNA | 1 [X] Yes 2 [ ] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 509 LINDEN LANE | 21869 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1942-1945 | 1 [ ] Yes 2 [X] No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 11 | | MACHINIST | MANUFACTURING |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| JAMES MURPHY | ANGENORA LAYTON |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| JAMES S. RICHARDSON, SR. | 9103 MIDLAND TURN, UPPER MARLBORO, MD 20772 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | ST. PAUL'S CEMETERY | 3/12/01 | VIENNA, MARYLAND |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Leonard D. Zeller | ZELLER FUNERAL HOME, P. O. BOX 207, 106 MAIN STREET, EAST NEW MARKET, MARYLAND 21631 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Arteriosclerotic Cardiovascular Disease | years |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 [ ] Yes 2 [X] No | 1 [ ] Yes 2 [ ] No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1 [ ] Yes 2 [X] No | Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] Yes 2 [ ] No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one)

1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| MD | D 47924 | 3-12-01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOMAN THANEY 300 AURORA STREET CAMBRIDGE MD 21613

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 13 2001 | G. Sparks |

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09140

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Robert Cecil McMahon, Jr.

2. Data of Daath — Month: March Day: 20, Year: 2001

3. Tima of Death: 12:15 am

4a. Facility Nama (If not institution, giva straat and number): Mariner Health Care of Laurel

4b. City, Town, or Location of Death: Laurel

4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 162-26-1518

6. Sex: XX M 2☐ F

7. Aga (In yrs. last birthday): 67 Yrs.

If Under 1 Yeer — Months: Days:

If Undar 24 Hrs. — Hours: Min.:

8. Data of Birth (Month, Day, Yaar): Apr 8, 1933

9. Birthplece (State or Foraign Country): Pennsylvania

Usual Rasidance of Dacedant

10a. Stata: Md.

10b. County: Prince George's

10c. City, Town or Location: Laurel

10d. Insida City Limits: 1☐ Yas 2 XX No

10e. Street and Numbar: 6215 Roblynn Road

10f. Zip Coda: 20707

10g. Citizen of What Country?: U.S.A.

11. Marital Stetus: 1☐ Never Marriad 2☒ Married 3☐ Widowad 4☐ Divorced

12. Was Decadant Evar in U.S. Armed Forcas? 1☒ Yes 2☐ No — If Yas, Giva Yaar or Datas:

13. Was Dacedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 1☐ Yas 2 XX No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highast grada complatad)

Elamantary/Secondary (0-12)

College (1-4or 5+): 4 years

18a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired): Electrical Engineer

16b. Kind of Businass/Industry: Westinghouse

17. Fathar's Nama (First, Middla, Last): Robert Cecil McMahon

18. Mothar's Nama (First, Middle, Maidan Surnama): Vera Chapman Brown

19a. Informant's Name/Ralationship (Type, Print): Bonnie McMahon / spouse

19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code): 6215 Roblynn Road Laurel, Maryland 20707

20a. Mathod of Disposition: 1☐ Burial 2 XX Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Othar (Spacify)

20b. Placa of Disposition (Nama of cemetery, crematory or othar place): Metro Crematory, Inc.

Data: March 20 2001

20c. Location - City or Town, Stata: Catonsville, Md.

21. Signature of Funaral Sarvica Licensaa: ▶ Gy S K / M00770

22. Nama and Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, Maryland 20707

**Physician /Medical Examiner**

23a. Part1. Entar tha disaasa, or complications that causad the daath. Do not antar tha mode of dying, such as cardiac or raspiratory errast, shock, or haart failura. List only ona causa on aach lina.

Approximata Intarval Batwaan Onset and Death

Immadiata Cause (Finel disaasa or condition rasulting in daath)

a. Metastatic Lung Cancer — 1 year

Due to (or as a consaquanca of):

Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Diseese or Injury that initiatad avants rasulting in daath) Last

b.

Due to (or as a consaquanca of):

c.

Due to (or as a consaquanca of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying cause givan in Part I.

Coronary Artery Disease

Hypertension

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☐ No 3 XX Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2 XX No

24b. Were autopsy findings availeble prior to completion of cause of daath? 1☐ Yas 2 XX No

25. Was casa referrad to madical exeminar? 1☐ Yas 2☒ No

26. Piece of Daath (Check only one) — Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA — Other: 4 XX Nursing Homa 5☐ Rasidanca 8☐ Othar (Specify)

27. Manner of Deeth: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarmined

28a. Date of Injury (Month, Day Yaar)

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Piece of Injury - At homa, farm, streat, factory, office building, atc. (Specify)

28f. Location (Straet and Number or Rural Routa Number, City or Town, Stete)

29a. Cartifier (Check only one) 1☐ **Certifying Physician:** To tha best of my knowledga, deeth occurrad at tha time, dete and place, and due to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, daath occurrad at tha tima, data and place, and dua to tha cause(s) and mannar steted.

29b. Signature and title of certifier: ▶

29c. License number: D25422

29d. Data signad (Month, Day, Yaar): March 20, 2001

30. Name and eddrass of parson who completed causa of death (Item 23a) (Type, Print): Robert Maggin, M.D. 13952 Baltimore Blvd. Laurel, Maryland 20707

**State Registrar**

31. Data filed (Month, Day, Yaar): MAR 22 2001

32. Registrar's Signature: ▶ B. Sparks

DHMH 16 Rev 6/95

---

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 09141

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): DOLORES MASLO

2. Date of Death: Month MAR Day 16 Year 2001

3. Time of Death: 1508

4a. Facility Name (If not institution, give street and number): Howard County General Hospital

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard

**Funeral Director**

5. Social Security Number: 578-58-7295

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 55 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 17, 1945

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Columbia

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 7332 Kindler Rd.

10f. Zip Code: 21046

10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nuclear Medicine Technologist

16b. Kind of Business/Industry: Medical

17. Father's Name (First, Middle, Last): Joseph A. Maslo

18. Mother's Name (First, Middle, Meiden Surname): Henrietta V. Kosalinsky

19a. Informant's Name/Relationship (Type, Print): Joseph Maslo / brother

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 6409 Reedy Song Knoll Clarksville, MD. 21029

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, crematory or other place): Metro Crematory

Date: Mar. 17 2001

20c. Location - City or Town, State: Catonsville, MD.

21. Signature of Funerel Service Licensee: [signature] M01092

22. Name end Address of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD. 21043

**Physician /Medical Examiner**

23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert feilure. List only one cause on each line.

Approximate Intervel Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Multi. System Organ Failure — 36hrs

Due to (or as a consequence of):

b. Sepsis — 12days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last

Due to (or as a consequence of):

c. Perforated Colon — 12dy

Due to (or as a consequence of):

d. Metastatic Endometrial Cancer — 30dy

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Right Tension Pneumothorax

Chemotherapy

Obstructive Cardiopathy Dilated

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of Certifier: [signature] MD

29c. License number: D51394

29d. Date Signed (Month, Day, Year): 3/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): N.P. Rao MD FACC 2360 Grace Dr. Columbia 21044

**State Registrar**

31. Date filed (Month, Day, Year): MAR 19 2001

32. Registrar's Signature: [signature] D. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 09142

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|
| Kenneth Powell McBride | March | 5 | 2001 | 1:43 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Sacred Heart Hospital | Cumberland | Allegany |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 226-26-6616 | 1 [X] M 2 [ ] F | 77 Yrs. | | | Oct. 11, 1923 | WV |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| WV | Hampshire | Paw Paw | 1 [ ] Yes 2 [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| HC 60 Box 31A | 25434 | US |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1943-1945 | 1 [ ] Yes 2 [X] No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Maintenance Mechanic | Railroad Tie Treatment Plant |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Earnest McBride | Velvia Powell |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Zeta McBride Wife | HC 60 Box 31A, Paw Paw, WV 25434 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Levels Cemetery | March 8, 2001 | Levels, WV |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Sandra Moyer | Shaffer Funeral Home 230 E. Main St., Romney, WV 26757 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. ACUTE MYOCARDIAL INFARCTION | 5 minutes |
| Due to (or as a consequence of): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. CORONARY ARTERY DISEASE | unknown |
| Due to (or as a consequence of): | | |
| | c. | |
| Due to (or as a consequence of): | | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1 [ ] Yes 2 [ ] No 9 [ ] Unknown | 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Severe anemia with pancytopenia

Diabetes Mellitus

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown | 1 [ ] Yes 2 [X] No | 1 [ ] Yes 2 [ ] No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 [ ] Yes 2 [X] No | Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] Yes 2 [ ] No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one)

1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | D 28184 | March 5 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baljeet Mahal, M.D. 909-13 Seton Drive Cumberland MD 21502

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 07 2001 | [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09143

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Bernadette Marie Malloy | March 01, 2001 | 1830 P |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 5806 Winding Ridge Way | Frederick | Frederick |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-34-4210 | 1☐ M 2☒ F | 64 Yrs. | | | 08-Sep-36 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Frederick | Frederick | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 5806 Winding Ridge Way | 21704- | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) | 14. Race - American Indien, Black, White, etc. |
|---|---|---|---|
| 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 11 | 0 | office supervisor | telephone company |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Meiden Sumeme) |
|---|---|
| Joseph Malloy | Margaret Murray |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Rosemarie Deffenbaugh daughter | 5806 Winding Ridge Way Frederick Maryland 21704- |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, cremetory or other piece) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | St. Patrick's Parish Cemetery | 05-Mar-01 | Mount Savage, Maryland |

| 21. Signeture of Funeral Service Licensee | 22. Neme end Address of Facility |
|---|---|
| John R Durst | Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximete Interval Between Onset and Death |
|---|---|---|
| Immediate Causa (Final disease or condition resulting in death) | e. METASTATIN LUNG CANCER | 5 MONTHS |
| | Due to (or as e consequence of): | |
| Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | b. | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or es e consequence of): | |
| | d. | |

Part tt. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☑ No | 1☐ Yes 2☑ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☑ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Dete of Injury (Month, Dey Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑ Natural 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |
| | 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) |

29e. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dale and place, and dua to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Joseph M. Haggerty MD | D32407 | MARCH 05, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JOSEPH M. HAGGERTY MD 9707 MEDICAL CTR DR ROCKVILLE MD. 20850

**State Registrar**

| 31. Dete filed (Month, Dey, Year) | 32. Registrer's Signature |
|---|---|
| MAR 07 2001 | Penny B Sparks |

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attanding Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

10
yes

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09144

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Frances Marion Mahaney
2. Date of Death (Month, Day, Year): Mar 9, 2001
3. Time of Death: 06:50am
4e. Facility Name (If not institution, give street and number): Cumberland Nursing Home
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

**Funeral Director**

5. Social Security Number: 216-22-7385
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sep 30, 1918
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Allegany
10c. City, Town or Location: Cumberland
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: Winifred & Williams Road
10f. Zip Code: 21502
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Former Employee
16b. Kind of Business/Industry: Textile

17. Father's Name (First, Middle, Last): James Franklin Rowan
18. Mother's Name (First, Middle, Maiden Surname): Mary B Ryan

19e. Informant's Name/Relationship (Type, Print): James W. Mahaney Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2924 Lake Valley Drive;Evansville, IN47711

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hillcrest Memorial Par
Date: 3/11/2001
20c. Location - City or Town, State: Cumberland, MD

21. Signature of Funeral Service Licensee: Nicholas J. Scarpelli
22. Name and Address of Facility: Scarpelli Funeral Home P.A. Cumberland, Maryland 21502

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Aspiration Pneumonitis — 2 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Anaemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Peter Halmos MD.
29c. License number: D04981
29d. Date signed (Month, Day, Year): Mar 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Peter Halmos Memorial Hospital Cumberland MD 21502

**State Registrar**

31. Date filed (Month, Day, Year): MAR 12 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at 955a

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09145

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): CATHERINE VIRGINIA MONGOLD

2. Date of Death (Month, Day, Year): MARCH 10 2001

3. Time of Death: 5:30 PM

4a. Facility Name (If not institution, give street and number): CUMBERLAND NURSING HOME

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

**Funeral Director**

5. Social Security Number: 214-62-4252

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): NOV. 22 1908

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: W.VA.

10b. County: MINERAL

10c. City, Town or Location: WILEY FORD

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: P.O.BOX# 179

10f. Zip Code: 26767

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CUMBERLAND GLASS COMPANY

16b. Kind of Business/Industry: INSPECTOR/FINAL FINISH

17. Father's Name (First, Middle, Last): JAMES HENRY NEWLEN

18. Mother's Name (First, Middle, Maiden Surname): SARAH ANN FLEMING

19a. Informant's Name/Relationship (Type, Print): CHARLES HUGH MONGOLD

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): HUSBAND P.O.Box#179 WILEY FORD W.VA. 26767

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): SUNSET CEMETERY

Date: MARCH 13 2001

20c. Location - City or Town, State: CUMBERLAND MARYLAND

21. Signature of Funeral Service Licensee: Wade L. Merritt

22. Name and Address of Facility: MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Coronary artery disease — 10 years.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D0033280

29d. Date signed (Month, Day, Year): March 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR SUNIL K. GUPTA 625 KENT AVE CUMBERLAND MARYLAND 21502

**State Registrar**

31. Date filed (Month, Day, Year): MAR 12 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

---

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09146

AUGUSTUS MCKENZIE 220-30-7864
**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): AUGUSTUS McKENZIE
2. Date of Death: Month MARCH, Day 12, Year 2001
3. Time of Death: 10:20 AM
4a. Facility Name (If not institution, give street and number): MEMORIAL HOSPITAL & MEDICAL CENTER
4b. City, Town, or Location of Death: CUMBERLAND,
4c. County of Death: ALLEGANY

**Funeral Director**

5. Social Security Number: 220 30 7864
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 68 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): 4-16-1932
9. Birthplace (State or Foreign Country): PA

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: PA
10b. County: Somerset
10c. City, Town or Location: Glencoe
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 3851 Glencoe Road
10f. Zip Code: 15538
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Raca - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 9; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Timber cutter
16b. Kind of Business/Industry: Lumbering

17. Father's Name (First, Middle, Last): Augustus McKenzie
18. Mother's Name (First, Middle, Meiden Surneme): Gladys Chisolm

19a. Informant's Name/Relationship (Type, Print): Betty P. McKenzie, wife
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 3851 Glencoe Road, Glencoe, PA 15538

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Mt. Lebanon Cemetery
Date: 3-16-01
20c. Location - City or Town, Stete: Glencoe, PA

21. Signeture of Funeral Service Licensee: Harvey H Zeigler
22. Name end Address of Facility: Harvey H. Zeigler FuneralHome, Hyndman, PA 15545

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart feilure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final diseese or condition resulting in death): a. Emphysema

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Left Lower Lobe Pneumonia

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1 [X] **Certifying Phyaician**: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and menner steted.

29b. Signature and title of certifier: M Sprenkle MD
29c. License number: D 54946
29d. Date signed (Month, Day, Year): 3/13/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. BOYD SPRENKLE, MEMORIAL HOSPITAL, 600 MEMORIAL AVE., CUMBERLAND, MD 21502

**State Registrar**

31. Date filed (Month, Day, Year): MAR 13 2001
32. Registrar's Signature: Barbara B Sparks

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

MD

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 09147

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| James | P. | Martin | MARCH 12 2001 | 4:20 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Sacred Heart Hospital | Cumberland | Allegany |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 292-34-7421 | 1 X M 2 ☐ F | 61 Yrs. | | | Jan 23, 1940 | MD |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| WV | Mineral | Fort Ashby | 1 ☐ Yes 2 X No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| P.O. Box 972 | 26719 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 X Divorced | 1 ☐ Yes 2 X No If Yes, Give Year or Dates: | 1 ☐ Yes 2 X No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | laborer | construction |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| James P. Martin | Edith Powell |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Rick Skelley uncle | P.O. Box 972; Fort Ashby WV 26719 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Scarpelli Funeral Home | 3/16/2001 | Cresaptown, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ James F Scarpelli | Scarpelli Funeral Home, P.A. Cumberland, MD 21502 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Poorly differentiated carcinoma of Mediastinum — 4 month

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. ____ Due to (or as a consequence of):

c. ____ Due to (or as a consequence of):

d. ____

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 9 ☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Acute renal failure, esophageal fistula, Malnutrition, C. diff colitis, Thrombocytopenia, Hypertension, Squamous cell carcinoma of left jaw

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 ☐ Yes 2 ☑ No | 1 ☐ Yes 2 ☑ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1 ☐ Yes 2 ☑ No | Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ Yes 2 ☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)

1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Husam Semaan, M.D. | D 56207 | MARCH 12, 2001 |

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

HUSAM SEMAAN Sacred Heart Hospital. Cumberland Maryland 21502

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 14 2001 | ▶ Donna G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

MD

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2001 09148

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| EDNA | MAE | MASLOW | MARCH 15 2001 | 6:00 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 119 NORTH ALLEGANY STREET | CUMBERLAND | ALLEGANY |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 460-22-5384 | 1☐ M 2☒ F | 75 Yrs. | | | OCT 13 1925 | TEXAS |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | ALLEGANY | CUMBERLAND | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 119 NORTH ALLEGANY STREET | 21502 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 1 | BOOK KEEPER | BOOK KEEPER |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| RUBEN KAPLON | JOHANNA GOLDSMITH |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| RICHARD MASLOW SON | 119 NORTH ALLEGANY STREET CUMBERLAND MARYLAND 21502 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | HILLCREST MEMORIAL PARK | MARCH 19 | 2001 DALLAS TEXAS |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Dale L. Merritt | MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Renal failure | 6 mths. |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Metastatic ovarian Cancer. | 6 mths |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, Hyperlipidemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☒ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one) 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Huma Shakil MD | D 46346 | MARCH 15, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR HUMA SHAKIL 625 KENT AVENUE CUMBERLAND MARYLAND 21502

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 16 2001 | Bonnie D Sparks |

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No: 2001 09149

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Harold L Nixon
2. Deta of Death Month/Dey/Year: March 21, 2001
3. Time of Death: 5:30 pm
4a. Facility Name *(If not institution, give street end number)*: 13634 Meadow Glenn
4b. City, Town, or Location of Death: Clarksville
4c. County of Death: Howard

**Funeral Director**

5. Social Security Number: 145-10-6662
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthdey)* Yrs.: 85
If Under 1 Year: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Year)*: Sep 29, 1915
9. Birthplace *(State or Foreign Country)*: New Jersey

Usuel Residence of Dacedant

10a. Stete: MD
10b. County: Howard
10c. City, Town or Location: Clarksville
10d. Insida City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 13634 Meadow Glenn
10f. Zip Code: 21029
10g. Citizen of Whet Country?: USA

11. Maritel Status: 1☐ Navar Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Give Yaar or Datas:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Maxican, Puarto Rican, atc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, atc. *Specify:* White

15. Decedant's Education *(Specify only highast grade completed)*: Elamantary/Secondery (0-12): 10 / College (1-4or 5+):
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Farmer
16b. Kind of Business/Industry: Farming

17. Fether's Neme *(First, Middle, Last)*: Warren Nixon
18. Mother's Name *(First, Middle, Meiden Surneme)*: Angeline Weatherby

19a. Informent's Neme/Reletionship *(Type, Print)*: Robert W. Nixon /son
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, Steta, Zip Code)*: 13534 Meadow Glenn, Clarksville, Maryland 21029

20a. Method of Disposition: 1☐ Buriel 2☐ Cramation 3☒ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetary, cremetory or other pleca)*: Marlboro 7th Day Baptist
Dete: 3/25/01
20c. Location - City or Town, Stete: Salem County, NJ

21. Signature of Funeral Service Licensee: ▶ [signature] M00773
22. Nema and Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complicetions thet causad the death. Do not anter the mode of dying, such es cardiac or respiretory errest, shock, or hanrt failure. List only ona cause on eech line.

Approximate Intervel Between Onset and Death

Immedlete Cause (Final diseese or condition resulting in daeth)
a. Carcinoma of lung with cerebral metastases — 2 years

Due to (or es a consaquenca of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disaase or Injury thet initieted events resulting in deeth) Last
b.
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other signficent conditions** contributing to death but not rasulting in the underlying cause givan in Part I.

23b. Did tobacco uee contribute to the cause of death? 1☒ Yee 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yas 2☒ No
24b. Were autopsy findings aveileble prior to completion of cause of death? 1☐ Yas 2☒ No

25. Wes case referred to medical exeminar? 1☐ Yas 2☒ No

26. Plece of Deeth *(Check only one)*: Hospital: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* son's home

27. Manner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Straat and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Phyeician:** To tha best of my knowledga, daath occurred at the tima, data and plece, and dua to tha causa(s) and manner as steted. 2☐ **Medical Examfner:** On the basis of examinetion end/or investigation, in my opinion, daeth occurred et the time, dete end plece, end due to the ceuse(s) end menner stated.

29b. Signeture and title of certifier: ▶ Donal M Billig MD
29c. Licansa number: D43927
29d. Date signed *(Month, Day, Year)*: March 22, 2001

30. Neme and eddress of person who complated causa of death (Item 23e) (Type, Print): Donal M. Billig, M.D. 13823 Outlet Drive, Silver Spring, Maryland 20904

**State Registrar**

31. Dete filed *(Month, Day, Year)*: MAR 22 2001
32. Registrer's Signetura: ▶ [signature]

DHMH 16 Rev 6/95

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

cgf

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2001 09150

**Physician - /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Grace Quill Noble | March 15, 2001 | 1:30 pm |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 2218 Mt. Hebron Drive | Ellicott City | Howard |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 219-26-7383 | 1☐ M 2☒ F | 98 Yrs. | | | Feb 12, 1903 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Howard | Ellicott City | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2218 Mt. Hebron Drive | 21042 | USA |

| 11. Marital Status | 12. Was Decedent Ever In U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 4 | Nurse | Health Care |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maidan Surname) |
|---|---|
| Maurice F. Quill | Julia A. Crook |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Josephine E. Thompson/Daughter | 2218 Mt. Hebron Drive, Ellicott City, MD 21042 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | St. Mary's Church Cem. | 3/20/01 | Laurel, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| M00160 | Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, MD 20707 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Adenocarcinoma of Colon | Months |
| | Due to (or as a consequanca of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequance of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic Progressive Dementia of Alzheimers

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☒ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Laurence R Gallagher, MD | D01786 | March 16, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Gallager 716 Maiden Choice Lane, Catonsville, MD 21228

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 19 2001 | Bruce G. Sparks |

**To be filed in Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09151

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Arthur Gilland Primrose

2. Date of Death: Month March Day 6, Year 2001

3. Time of Death: 8:53 PM

4a. Facility Name (If not institution, give street and number): 9622 Trepid Road

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 218-60-3588

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 47 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 5, 1953

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 9622 Trepid Road

10f. Zip Code: 21236

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Senior Operations Instructor

16b. Kind of Business/Industry: Balt. Gas & Electric

17. Father's Name (First, Middle, Last): Samuel F. Primrose

18. Mother's Name (First, Middle, Maiden Surname): M. Catherine Gilland

19a. Informant's Name/Relationship (Type, Print): Mrs. Kathleen M. Primrose (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9622 Trepid Road, Baltimore, MD 21236

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Bayview Crematory, Inc.

Data: 3/10/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Renal Cell Cancer — 1yr 3mos

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D44576

29d. Date signed (Month, Day, Year): 3/9/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Samuel Denmeade 1650 Orleans St Baltimore MD 2123

**State Registrar**

31. Date filed (Month, Day, Year): MAR 12 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 09152

NAME KNOWN TO PHYSICIAN: PISULA, FREDERICK A.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Physician /Medical Examiner** — To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last): Frederick Anthony Pisula
2. Date of Death (Month, Day, Year): MARCH 10, 2001
3. Time of Death: 4:40AM
4a. Facility Name (If not institution, give street and number): VA MARYLAND HEALTH CARE SYSTEM
4b. City, Town, or Location of Death: PERRY POINT
4c. County of Death: CECIL

**Funeral Director**

5. Social Security Number: 165-22-2883
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 73 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 05/30/1927
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD
10b. County: Harford
10c. City, Town or Location: Havre de Grace
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 3637 Old Level Road
10f. Zip Code: 21078
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: 1955-59
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4or 5+): 2 Years
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Metal Finisher
16b. Kind of Business/Industry: Factory

17. Father's Name (First, Middle, Last): Joseph Pisula
18. Mother's Name (First, Middle, Maiden Surname): Stephaney Bazan

19a. Informant's Name/Relationship (Type, Print): Peggy L. Pisula- Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3637 Old Level Rd., Havre de Grace, MD 21078

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Harford Memorial Grdns
Date: 3/13/01
20c. Location - City or Town, State: Aberdeen, MD

21. Signature of Funeral Service Licensee: Elaine M. Smith
22. Name and Address of Facility: Mitchell-Smith Funeral Home, P.A. 123 S. Washington St, Havre de Grace, MD 21078

**Physician /Medical Examiner** — Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. CARCINOMA OF LIVER | 2 MONTHS |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | b. | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

HYPOTHYROIDISM

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Samir Kheiri MD
29c. License number: D0052064
29d. Date signed (Month, Day, Year): MARCH 10, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SAMIR KHEIRI, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MARYLAND 21902

**State Registrar**

31. Date filed (Month, Day, Year): MAR 13 2001
32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

2001 09153

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Robison Brauff Patton, Jr. | | 2. DATE OF DEATH (Month, Day, Year): March 11, 2001 | 3. TIME OF DEATH: 8:00 P.M.M |
| 4. SOCIAL SECURITY NUMBER: 177-18-3680 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 82 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): Aug. 15, 1918 |
| 8. BIRTHPLACE (State or Foreign Country): Pennsylvania | | | |
| 9a. FACILITY NAME (If not institution, give street and number): 333 Roberts Way | 9b. CITY, TOWN OR LOCATION OF DEATH: Aberdeen | 9c. COUNTY OF DEATH: Harford | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Harford | 10c. CITY, TOWN OR LOCATION: Aberdeen | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 333 Roberts Way | 10f. ZIP CODE: 21001 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WW II | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+): 8 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Mathematician | 16b. KIND OF BUSINESS/INDUSTRY: U.S. Government |
| 17. FATHER'S NAME (First, Middle, Last): Robison B. Patton, Sr. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Lily M. Klein | |
| 19a. INFORMANT'S NAME (Type/Print): Jackie S. Miller (Daughter) | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 24512 Hanson Rd., Gaithersburg, MD 20882 | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify) | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Harford Mem. Gdns. Mausoleum DATE: 3/14 | 20c. LOCATION — City or Town, State: Aberdeen, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Kenneth B Cargo | 22. NAME AND ADDRESS OF FACILITY: Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Metastatic Carcinoma | 8-21-00 |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Carcinoma of the Pancreas | 8-21-00 |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | c. | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA. OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

| | | | |
|---|---|---|---|
| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: D-15994 | 29d. DATE SIGNED (Month, Day, Year): 3-12-01 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): LETICIA S. GALVEZ, M.D., 625 S. UNION AVE., HAVRE DE GRACE, MD. 21078

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAR 13 200 | 32. REGISTRAR'S SIGNATURE: [signature] |

DHMH-16 Rev 1/89

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09154

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): VAN R. PRITTS

2. Date of Death: Month Feb. Day 12 Year 2001

3. Time of Death: 12:15 a.m.

4a. Facility Name (If not institution, give street and number): 18518 McMullen Highway, S.W.

4b. City, Town, or Location of Death: Rawlings

4c. County of Death: Allegany

**Funeral Director**

5. Social Security Number: 233-34-6013

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 77 Yrs.

If Under 1 Year: Months Days

If Under 24 Hrs.: Hours Min.

8. Date of Birth (Month, Day, Year): Oct. 5,1923

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: WV

10b. County: Mineral

10c. City, Town or Location: New Creek

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: HC 72, Box 173

10f. Zip Code: 26743

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner/Operator

16b. Kind of Business/Industry: Lumber Company

17. Father's Name (First, Middle, Last): Earl F. Pritts

18. Mother's Name (First, Middle, Maiden Surname): Viola Brant

19a. Informant's Name/Relationship (Type, Print): Diane Sulkowski/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 18518 McMullen Highway, S.W. Rawlings, MD 21557

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Potomac Memorial Gardens

Date: Feb. 15 2001

20c. Location - City or Town, State: Keyser, WV

21. Signature of Funeral Service Licensee: Brian L. Smith

22. Name and Address of Facility: Smith Funeral Home 85 S. Main Street Keyser, WV 26726

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration Pneumonia — 2 weeks

Due to (or as a consequence of):

b. Multiple Sclerosis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Arteriosclerotic Vascular Disease

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Daughter's Residence

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rabie Zalzal

29c. License number: 16515

29d. Date signed (Month, Day, Year): March 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Rabie Zalzal, M.D. 537 S. Mineral Street Keyser, WV 26726

**State Registrar**

31. Date filed (Month, Day, Year): MAR 27 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09155

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: ELEANOR LUCILLE PRICE

2. Date of Death — Month: MARCH Day: 3, Year: 2001

3. Time of Death: 1715

4a. Facility Name *(If not institution, give street and number)*: ALLEGANY COUNTY NURSING HOME

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

**Funeral Director**

5. Social Security Number: 215-10-7212

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 94 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: SEPT. 20, 1906

9. Birthplace *(State or Foreign Country)*: MARYLAND

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD

10b. County: ALLEGANY

10c. City, Town or Location: LAVALE

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 11015 GEORGIA AVENUE, NW

10f. Zip Code: 21502

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): 8 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER

16b. Kind of Business/Industry: HOME

17. Father's Name *(First, Middle, Last)*: WILLIAM ADDISON MARTIN

18. Mother's Name *(First, Middle, Maiden Surname)*: LILLIAN RIZER

19a. Informant's Name/Relationship *(Type, Print)*: VIVIAN L. HORN / DAUGHTER

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2601 BLITHE DRIVE, CHESTER, VA 23831

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: HILLCREST BURIAL PARK — Date: 03/10/2001

20c. Location - City or Town, State: CUMBERLAND, MD

21. Signature of Funeral Service Licensee: Howard A. Upchurch

22. Name and Address of Facility: UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. HYPERTENSIVE CARDIOVASCULAR DISEASE — 2 YRS.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 8☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robertiano J. Barrera, Jr.

29c. License number: D-14865

29d. Date signed *(Month, Day, Year)*: MARCH 5, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Robertiano J. Barrera, Jr. M.D. 560 Memorial Ave, Suite 201, Cumberland, MD 21502

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 07 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

---

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

2001 09156

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Catherine Irene Reeves | | | 2. DATE OF DEATH: MARCH 8 2001 | 3. TIME OF DEATH: 7:03 PM |
| 4. SOCIAL SECURITY NUMBER: 218-07-1340 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 89 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): May 5, 1911 | 8. BIRTHPLACE (State or Foreign Country): Pennsylvania |
| 9a. FACILITY NAME (If not institution, give street and number): 1211 Main Street | | 9b. CITY, TOWN OR LOCATION OF DEATH: Darlington | | 9c. COUNTY OF DEATH: Harford |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Harford | 10c. CITY, TOWN OR LOCATION: Darlington | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1211 Main Street | | 10f. ZIP CODE: 21034 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+): 0 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: IN home | | |
| 17. FATHER'S NAME (First, Middle, Last): George Freese | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Linnie M. Fitz | | |
| 19a. INFORMANT'S NAME (Type/Print): Margaret Reeves (Daughter) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1211 Main Street, Darlington, Maryland 21034 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Darlington Cemetery | DATE: 3/12/01 | 20c. LOCATION — City or Town, State: Darlington, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | 22. NAME AND ADDRESS OF FACILITY: Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CONGESTIVE HEART FAILURE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. AORTIC STENOSIS | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: HYPERTENSION

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 26e. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF INJURY M | 26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 26d. DESCRIBE HOW INJURY OCCURED | | |
| | 26g. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] MD | D25057 | ▶ MARCH 9, 2001 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): VIJAY M. ABHYANKAR 2 NORTH AVENUE BEL AIR MD 21014

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAR 9 - 2001 | [signature] |

DHMH-16 Rev 1/89

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 09157

**Physician /Medical Examiner**

1. Decedent's Neme *(First, Middle, Last)*: James Rowe

2. Dete of Deeth — Month: March; Day: 14; Year: 2001

3. Time of Deeth: 10:20 pm

4e. Facility Neme *(If not institution, give street and number)*: 9019 Manorwood Road

4b. City, Town, or Location of Deeth: Laurel

4c. County of Deeth: Howard

**Funeral Director**

5. Sociel Security Number: 122-03-2476

6. Sex: XX 1 M 2 F

7. Age *(In yrs. last birthday)*: 80 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 18 1920

9. Birthplace *(State or Foreign Country)*: New Jersey

Usuel Residence of Decedent

10a. Stete: MD

10b. County: Howard

10c. City, Town or Location: Laurel

10d. Insida City Limits: 1 Yes XX No

10e. Street and Number: 9019 Manorwood Road

10f. Zip Code: 20723

10g. Citizen of What Country?: USA

11. Maritel Stetus: 1 Never Married XX Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 XX Yes 2 No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1 Yes 2 X No *Specify:*

14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 12; College (1-4or 5+): 2

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Sales

16b. Kind of Business/Industry: Automobile

17. Fether's Neme *(First, Middle, Last)*: Unknown

18. Mothar's Nama *(First, Middle, Meiden Surneme)*: Unknown

19a. Informent's Neme/Retationship *(Type, Print)*: Norma L. Rowe/Wife

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9019 Manorwood Road, Laurel, MD 20723

20e. Method of Disposition: 1 Buriel 2 XX Cremation 3 Removal from State 4 Donetion 5 Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other place)*: Metro Crematory Inc.

Dete: 3/20/01

20c. Location - City or Town, Stete: Catonsville, MD

21. Signeture of Funerel Service Licensee: /M00773

22. Neme and Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, MD 20707

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Deeth

Immediete Ceuse (Finel diseese or condition resulting in daath)

e. Mesothelioma — 2 years

Dua to (or es a consequence of):

Sequentielly list conditions, if eny, leading to immediete cause. Entar Underlying Cause (Diseese or injury thet initieted events resulting in daeth) Lest

b.

Due to (or es e consaquence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significent conditions** contributing to deeth but not rasulting in the underlying cause given in Part t.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

24a. Wes an eutopsy performed? 1 Yes 2 X No

24b. Were autopsy findings eveilebte prior to completion of cause of deeth? 1 Yes 2 X No

25. Was case referred to medical exeminer? 1 Yas 2 X No

26. Piece of Death *(Check only one)*: Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA; Other: 4 Nursing Home 5 X Residence 8 Other *(Specify)*

27. Manner of Deeth: 1 X Naturel 2 Accident 3 Suicide 4 Homicida 5 Pending investigation 6 Could not be determined

28e. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury et Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1 X **Certifying Physicien:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) and menner es stated. 2 **Medical Examiner:** On the basis of examination end/or Investigetion, in my opinion, daeth occurrad et tha time, data and ptace, and due to the cause(s) and menner steted.

29b. Signeture and title of certifier: Kevin J. Shannon MD

29c. License number: D0053829

29d. Date signed *(Month, Day, Year)*: 3/15/01

30. Nama and address of parson who completed cause of deeth (Item 23e) (Type, Print): 7525 Greenway Center Drive Greenbelt, Maryland

**State Registrar**

31. Dete filed *(Month, Day, Year)*: MAR 19 2001

32. Registrer's Signetura: G. Sparks

DHMH 16 Rev 6/95

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09158

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): JAMES LEONARD ROOT
2. Date of Death (Month, Day, Year): MARCH 6 2001
3. Time of Death: 2:00 AM
4a. Facility Name (If not institution, give street and number): 11900 KNOB ROAD N.E.
4b. City, Town, or Location of Death: CUMBERLAND
4c. County of Death: ALLEGANY

**Funeral Director**

5. Social Security Number: 217-10-1799
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JULY 26 1919
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ALLEGANY
10c. City, Town or Location: CUMBERLAND
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 11900 KNOB ROAD N.E.
10f. Zip Code: 21502
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1944-1945
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ENGINEER B&O RAILROAD
16b. Kind of Business/Industry: RAILROAD/ENGINEER

17. Father's Name (First, Middle, Last): JAMES E. ROOT
18. Mother's Name (First, Middle, Maiden Surname): EDITH BISHOP

19a. Informant's Name/Relationship (Type, Print): HILDA M. ROOT WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11900 KNOB ROAD N.E. CUMBERLAND MARYLAND 21502

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ROCKY GAP VET CEMETERY | Date: MARCH 9 2001
20c. Location - City or Town, State: RFD FLINTSTONE MD.

21. Signature of Funeral Service Licensee: Dale L. Merritt
22. Name and Address of Facility: MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Myocardial infarction | unknown |
| Due to (or as a consequence of): b. | Coronary atherosclerosis | 20 yr + |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: Due to (or as a consequence of): c. | | |
| Due to (or as a consequence of): d. | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: HBP; ischemic cardiomyopathy

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Anthony J. Bollino J. M.D.
29c. License number: D 17565
29d. Date signed (Month, Day, Year): MARCH 7, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR ANTHONY J. BOLLINO JR. 922 NATIONAL HIGHWAY LAVALE, MARYLAND 21502

**State Registrar**

31. Date filed (Month, Day, Year): MAR 08 2001
32. Registrar's Signature: Donna D Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 09159

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Carlos Michael Robison
2. Date of Death (Month, Day, Year): Mar 9, 2001
3. Time of Death: 10:15am
4a. Facility Name (If not institution, give street and number): New Hope Personal Care Home
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

**Funeral Director**

5. Social Security Number: 705-14-2236
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sep 9, 1914
9. Birthplace (State or Foreign Country): WV

Usual Residence of Decedent

10a. State: WV
10b. County: Mineral
10c. City, Town or Location: Ridgeley
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 106 Pineview Drive
10f. Zip Code: 26753
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Trackman
16b. Kind of Business/Industry: B&O Railroad

17. Father's Name (First, Middle, Last): Solomon Robison
18. Mother's Name (First, Middle, Maiden Surname): Bertha (Kaylor)

19a. Informant's Name/Relationship (Type, Print): Mary M. Robison Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 106 Pineview Drive;Ridgeley, WV26753

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Fort Ashby Cemetery
Date: 3/11/2001
20c. Location - City or Town, State: Fort Ashby, WV

21. Signature of Funeral Service Licensee: Nicholas J. Scarpelli
22. Name and Address of Facility: Scarpelli Funeral Home P.A. Cumberland, Maryland 21502

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cerebrovascular Accident — 15 minutes
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Personal Care Home

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robustiano J. Barrera, Jr
29c. License number: D14865
29d. Date signed (Month, Day, Year): Mar 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robustiano J. Barrera M.D. Mem. Hosp Med Bldg Cumberland MD 21502

**State Registrar**

31. Date filed (Month, Day, Year): MAR 13 2001
32. Registrar's Signature: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09160

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: GERALD KLENZO SHELTON
2. Date of Death Month / Day / Year: MAR 10, 2001
3. Time of Death: 17:35 AM
4a. Facility Name *(If not institution, give street and number)*: 3402 Carvale Drive
4b. City, Town, or Location of Death: 21001
4c. County of Death: Harford

**Funeral Director**

5. Social Security Number: 246-44-5351
6. Sex: [X] 1 M 2 F
7. Age *(In yrs. last birthday)*: 68 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Aug. 8, 1932
9. Birthplace *(State or Foreign Country)*: North Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Aberdeen
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 3402 Carvale Drive
10f. Zip Code: 21001
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates: 1953-55
13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): — College (1-4 or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Owner-Operator
16b. Kind of Business/Industry: Cab Company

17. Father's Name *(First, Middle, Last)*: Hobson Dewey Shelton
18. Mother's Name *(First, Middle, Maiden Surname)*: Nancy Ellen Wheely

19a. Informant's Name/Relationship *(Type, Print)*: Berta R. Shelton/ Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3402 Carvale Drive, Aberdeen, MD 21001

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Harford Memorial Gardens
Date: 3-14-01
20c. Location - City or Town, State: Aldino, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ASCVD
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] DME
29c. License number: 0 CME
29d. Date signed *(Month, Day, Year)*: MARCH 10, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GRADY MD 728 BELAIR RD BELAIR MD 21014

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 13 2001
32. Registrar's Signature: [signature] B. Sparks

DHMH 16 Rev 6/95

---

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0020**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Division of Vital Records, P.O. Box 68760,**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09161

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: EDITH LAWS SPANN
2. Date of Death Month Dey Year: March 7, 2001
3. Time of Death: 0744
4a. Facility Name *(If not institution, give street and number)*: The Memorial Hospital at Easton
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

**Funeral Director**

5. Social Security Number: 577-07-9855
8. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 86 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: DEC 4 1914
9. Birthplace *(State or Foreign Country)*: WASH. D.C.

Usual Residence of Decedent

10a. State: MD
10b. County: TALBOT
10c. City, Town or Location: EASTON
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 501 DUTCHMANS LANE
10f. Zip Code: 21601
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11; College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name *(First, Middle, Last)*: JOHN THORNLEY LAWS
18. Mother's Name *(First, Middle, Maiden Surname)*: ANNIE LOUISE HUNTER

19a. Informant's Name/Relationship *(Type, Print)*: GEORGE KENT SPANN/SON
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 29311 WOODRIDGE DR. EASTON, MD 21601

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: CHESAPEAKE CREMATION CTR
Date: 3-7-01
20c. Location - City or Town, State: STEVENSVILLE, MD

21. Signature of Funeral Service Licensee: Maura E Newnam FD (FSP
22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. myocardial infarction — 5 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Nancy Lawnsnead
29c. License number: H 53369
29d. Date signed *(Month, Day, Year)*: 3/7/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): NANCY SNOW O.D. 219 S. WASHINGTON ST EASTON, MD 21601

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 0 8 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

Edith Spann

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**To the Hospital or Attending Physician:** The law requires that this death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 09162

SIMPSON, BESSIE 217-42-6219
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): BESSIE SIMPSON
2. Date of Death (Month, Day, Year): MARCH 4 2001
3. Time of Death: 13:25
4a. Facility Name (If not institution, give street and number): Memorial Hospital & Medical Center
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

**Funeral Director**

5. Social Security Number: 217-42-6219
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 58 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 13, 1942
9. Birthplace (State or Foreign Country): West Virginia

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: WV
10b. County: Mineral
10c. City, Town or Location: Keyser
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: Rt. 6, Box 6594 Knobley Road
10f. Zip Code: 26726
10g. Citizen of What Country?: USA
11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home
17. Father's Name (First, Middle, Last): Virgil Samuel Moorehead
18. Mother's Neme (First, Middle, Maiden Surname): Gladys Marie Cummings
19a. Informant's Name/Reletionship (Type, Print): George Homer Simpson/Husband
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 714 Keyser, WV 26726
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Biser Cemetery
Date: March 7 2001
20c. Location - City or Town, State: Keyser, WV
21. Signature of Funeral Service Licensee: ▶ Brian L. Smith
22. Neme and Address of Facility: Smith Funeral Home 85 S. Main Street Keyser, WV 26726

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseasa or condition resulting in death): a. Metastatic Ovarian Cancer — 1 year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc.) (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶
29c. License number: D36766
29d. Date signed (Month, Day, Year): MARCH 6, 2001

3

30. Nama and address of person who completed cause of death (Item 23e) (Type, Print): DR. VIK POONAI, SETON DRIVE, CUMBERLAND, MD 21502

**State Registrar**

31. Date filed (Month, Day, Year): MAR 0 8 2001
32. Registrar's Signature: ▶ George D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Amended #25, ntw, 3/8/01, Allegany Co.

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

## *Certificate of Death*

Reg. No. 2001 09163

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Homer E. Schade

2. Date of Death: Month March Day 6 Year 2001

3. Time of Death: 5:22 a.m.

4a. Facility Name (If not institution, give street and number): Memorial Hospital & Medical Center

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

**Funeral Director**

5. Social Security Number: 214-07-4938

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug 28, 1916

9. Birthplace (State or Foreign Country): WV

Usual Residence of Decedent

10a. State: MD

10b. County: Allegany

10c. City, Town or Location: Cumberland

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 407 Caroline Street

10f. Zip Code: 21502

10g. Citizen of What Country? USA

11. Meritel Stetus: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☒ Yes 2☐ No If Yes, Give Yaar or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yas 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highast grade completed): Elamentary/Secondary (0-12): 12; Collega (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired): Truck Driver

16b. Kind of Business/Industry: Textile

17. Fathar's Name (First, Middle, Last): George Peter Schaidt

18. Mother's Nama (First, Middle, Maiden Sumama): Nellie B (See)

19a. Informant's Name/Ralationship (Type, Print): Virginia Schade wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 407 Caroline Street; Cumberland MD 21502

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)

20b. Place of Disposition (Nama of cematary, cramatory or othar place): Sunset Memorial Park

Data: 3/09/2001

20c. Location - City or Town, Stata: Cumberland, MD

21. Signature of Funeral Service Licensee: Nicholas J. Scarpelli

22. Name and Address of Facility: Scarpelli Funeral Home, P.A. Cumberland, MD 21502

**Physician /Medical Examiner**

23a. Part1. Entar tha disaasa, or complications that caused the death. Do not anter tha moda of dying, such as cardiac or raspiratory arrest, shock, or heart feiiura. List only one causa on aach lina.

Approximata Intarval Batween Onset and Daath

Immediate Causa (Final disaasa or condition resulting in daath)

a. Hyperosmolar Nonketotic Coma — 4 days

Dua to (or as a consequance of):

Sequentially list conditions, if any, leading to immediata causa. Entar Underlying Cause (Diseasa or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequance of):

d.

Mar 7 2001

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa given in Part I.

Multi-infarct Dementia, Renal Failure

23b. Did tobacco use contributa to the causs of death? 1☐ Yas 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Ware autopsy findings availeble prior to completion of cause of death? 1☐ Yas 2☐ No

25. Was case rafarred to medical examiner? 1☒ Yas 2☐ No Released

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Homa 5☐ Residanca 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Year)

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, straet, factory, offica building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the tima, data and place, and due to tha causa(s) and mannar as stated. 2☐ **Medical Examiner**: On tha basis of axamination and/or investigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and mannar stated.

29b. Signatura and title of certifier:

29c. License number: D0033280

29d. Data signad (Month, Day, Year): March 6, 2001

30. Name and address of person who completed causa of daath (Item 23a) (Type, Print): Dr. Sunil K. Gupta 625 Kent Avenue Suite 101 Cumberland, MD 21502

**State Registrar**

31. Data filed (Month, Day, Year): MAR 08 2001

32. Registrar's Signatura: Barbara G Sparks

ORIGINAL

DHMH 16 Rev 6/95

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

6

MS

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09164

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Della Pearl Shumaker

2. Date of Death: Month March, Day 6, Year 2001

3. Time of Death: 11:40 PM

4a. Facility Name (If not institution, give street and number): Randolf Hills Nursing Home

4b. City, Town, or Location of Death: Wheaton

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 215-14-6300

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov 24, 1921

9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince Georges

10c. City, Town or Location: Cheverly

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2326 Cheverly Ave.

10f. Zip Code: 20785

10g. Citizen of What Country? USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 5; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: own home

17. Father's Name (First, Middle, Last): Unknown

18. Mother's Name (First, Middle, Maiden Surname): Unknown

19a. Informant's Name/Relationship (Type, Print): Erma Istvan-Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2326 Cheverly Ave., Cheverly, MD 20785

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Sunset Memorial Park

Date: March 10, 2001

20c. Location - City or Town, State: Cumberland, MD

21. Signature of Funeral Service Licensee: Douglas S Hafer

22. Name and Address of Facility: Hafer Chapel of the Hills Mortuary, 1302 National Hwy, LaVale, MD 21502

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular Accident — Two Weeks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypertension — Ten Years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D37975

29d. Date signed (Month, Day, Year): March 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. JEFFREY INDRISANO, 10801 LOCKWOOD DR., SILVER SPRING, MD 20901

**State Registrar**

31. Date filed (Month, Day, Year): MAR 12 2001

32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Amended #19a, mlw, 3/5/01, Allegany Co.

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09165

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Wanda C. Stewart
2. Date of Death (Month, Day, Year): Feb. 17, 2001
3. Time of Death: 14:43
4a. Facility Name (If not institution, give street and number): Memorial Hospital & Medical Center
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

**Funeral Director**

5. Social Security Number: 218-64-8372
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 47 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 8, 1953
9. Birthplace (State or Foreign Country): WV

Usual Residence of Decedent

10a. State: WV
10b. County: Mineral
10c. City, Town or Location: Piedmont
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 41 Lyons Street
10f. Zip Code: 26750
10g. Citizen of What Country?: USA
11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nursing Assistant
16b. Kind of Business/Industry: Nursing Home
17. Father's Name (First, Middle, Last): Frederick O. Green
18. Mother's Name (First, Middle, Maiden Surname): Georgia B. Evans
19a. Informant's Name/Relationship (Type, Print): Chris Green ~~Christ Greet~~ - Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 21418 Creekside Drive SW #2; Westernport, MD 21562
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Potomac Memorial Gardens
Date: 2/20/01
20c. Location - City or Town, State: Keyser, WV
21. Signature of Funeral Service Licensee: Wm H Duffy
22. Name and Address of Facility: Fredlock Funeral Home, Piedmont, WV 26750

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Congestive Heart Failure — 2 weeks
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Diabetes Mellitus with Diabetic Nephropath and Renal Insufficiency

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No
25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Mark Sagin MD
29c. License number: D35481
29d. Date signed (Month, Day, Year): Feb. 23, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Mark Sagin Memorial Hospital Suite 400; Cumberland, MD 21502

**State Registrar**

31. Date filed (Month, Day, Year): FEB 23 2001
32. Registrar's Signature: Geneva B Sparks

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3/9 MLW

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

AMENDED ITEMS #19a & b per fh G791 012401 SS
AMEND ITEM: 19B PER F.H. G791 1-19-01 WR.

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09166

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Margaret M. Spellman
2. Date of Death (Month, Day, Year): January 2, 2001
3. Time of Death: 10:03 AM
4a. Facility Name (If not institution, give street and number): Harford Memorial Hospital
4b. City, Town, or Location of Death: Havre De Grace
4c. County of Death: Harford

**Funeral Director**

5. Social Security Number: 040-09-1322
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 29, 1915
9. Birthplace (State or Foreign Country): RI

Usual Residence of Decedent

10a. State: MD
10b. County: Harford
10c. City, Town or Location: Abingdon
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 20 Box Hill So. Parkway
10f. Zip Code:
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): Lewis Ide
18. Mother's Name (First, Middle, Maiden Surname): Mary Feeney

19a. Informant's Name/Relationship (Type, Print): Joseph ~~John~~ F. Spellman / Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 91 Olive Street, #3C New Haven, CT 06511 ~~71 Olive Street # 3C New Haven CT 06511~~

20a. Method of Disposition: ☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St Lawrence Cemetery
Date: Jan. 6, 2001
20c. Location - City or Town, State: West Haven, CT

21. Signature of Funeral Service Licensee: Victor P. Doda, Jr.
22. Name and Address of Facility: Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ~~Acute~~ Myocardial Infarction — About one hour
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Essential Hypertension
Hypercholesteralemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D19583
29d. Date signed (Month, Day, Year): January 2, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MANUEL M. LAZATIN MD 8 Law Street, Aberdeen, Maryland 21001

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

**State Registrar**

31. Date filed (Month, Day, Year): JAN 04 2001
32. Registrar's Signature: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Dr Lazatin 1003 1/2/01 Margaret Spellman

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09167

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Antonio A. Trotta, Jr.

2. Date of Death: Month: mar Day: 9 Year: 2001

3. Time of Death: 1:30 Am

4a. Facility Name (If not institution, give street and number): Mariner Health of Bel Air

4b. City, Town, or Location of Death: Bel Air

4c. County of Death: Harford

**Funeral Director**

5. Social Security Number: 214-36-7700

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 60 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 08/01/1940

9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md.

10b. County: Harford

10c. City, Town or Location: Bel Air

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 705 S. Atwood Road

10f. Zip Code: 21014

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th grade; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): beautician

16b. Kind of Business/Industry: local barbers

17. Father's Name (First, Middle, Last): Antonio A. Trotta, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Wilhelmina DiNenna Trotta

19a. Informant's Name/Relationship (Type, Print): Sandy O. Trotta

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 705 S. Atwood Road, Bel Air, Md. 21014

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Most Holy Redeemer Cem.

Date: 03/12/01

20c. Location - City or Town, State: Baltimore

21. Signature of Funeral Service Licensee: Brian A. Wellen

22. Name and Address of Facility: Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 21014

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Lung Cancer, metastatic — 6mm

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D28339

29d. Date signed (Month, Day, Year): March 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GNDA PHYSICIAN 101 E. Wheel Road Bel Air MD 21015

**State Registrar**

31. Date filed (Month, Day, Year): MAR 13 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Trotta Antonio
SM
3

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09168

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): LUCILLE HUTCHINGS VIVIAN
2. Date of Death: Month MARCH Day 4 Year 2001
3. Time of Death: 9:40 AM
4a. Facility Name (If not institution, give street and number): TALBOT HOSPICE HOUSE
4b. City, Town, or Location of Death: EASTON
4c. County of Death: TALBOT

**Funeral Director**

5. Social Security Number: 142-60-6266
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 76 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): SEPT. 28, 1924
9. Birthplace (State or Foreign Country): BERMUDA

Usual Residence of Decedent

10a. State: MD
10b. County: TALBOT
10c. City, Town or Location: OXFORD
10d. Inside City Limits: 1☐ Yes 2☐ No XX
10e. Street and Number: 5833 DEEPWATER DRIVE
10f. Zip Code: 21654
10g. Citizen of What Country?: BERMUDA
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): INTERIOR DESIGNER
16b. Kind of Business/Industry: HOME DECORATING
17. Father's Name (First, Middle, Last): NATHANIEL W. HUTCHINGS
18. Mother's Name (First, Middle, Maiden Surname): FLORENCE SARAH SHUTER
19a. Informant's Name/Relationship (Type, Print): DIANA V. BRIAN/DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5833 DEEPWATER DRIVE, OXFORD, MD 21654
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CHESAPEAKE CREMATION CTR
Date: 3-07-01
20c. Location - City or Town, State: STEVENSVILLE, MD
21. Signature of Funeral Service Licensee: Maura E Newnam LIC CFSP
22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Metastatic small bowel cancer | 4mos. |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Parkinson's disease
Hypertension
Coronary artery disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Talbot Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Hollywood MD
29c. License number: D46820
29d. Date signed (Month, Day, Year): 3/5/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JENNIFER HOLLYWOOD M.D. 506 IDLEWILD AVE EASTON, MD 21601

**State Registrar**

31. Date filed (Month, Day, Year): MAR 0 6 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 09169

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Gorman W. White, Sr.

2. Date of Death: Month March Day 8, Year 2001

3. Time of Death: 11:35 PM

4a. Facility Name (If not institution, give street and number): Gilchrist Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 217-07-0759

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 30, 1919

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 6451 N. Charles St., Suite 125

10f. Zip Code: 21212

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Rece - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th Grade

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mechanical Engineer

18b. Kind of Business/Industry: Screen Company

17. Father's Name (First, Middle, Last): Polk White

18. Mother's Name (First, Middle, Maiden Surname): Della Owens

19a. Informant's Name/Relationship (Type, Print): Mr. Gorman W. White, Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1905 Nelson Mill Rd., Jarrettsville, MD 21084

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) Entombment

20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cem. Maus.

Date: 3/12/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Brian A. Miller

22. Name and Address of Facility: Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Dementia — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) hospice

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier: Helen M Gordon

29c. License number: D0051926

29d. Date signed (Month, Day, Year): March 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Helen M Gordon MD 6565 N. Charles St Baltimore MD 21204

**State Registrar**

31. Date filed (Month, Day, Year): MAR 12 2001

32. Registrar's Signature: D. Sparks

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

WHITE, GORMAN - MARCH 8, 2001 @ 11:35 PM

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09170

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: David White

2. Date of Death (Month, Day, Year): March 8, 2001

3. Time of Death: 2000

4a. Facility Name *(If not institution, give street and number)*: The Memorial Hospital at Easton

4b. City, Town, or Location of Death: Easton

4c. County of Death: Talbot

**Funeral Director**

5. Social Security Number: 216-16-7194

6. Sex: 1 ☑ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 3, 1923

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Talbot

10c. City, Town or Location: Trappe

10d. Inside City Limits: 1 ☐ Yes 2 ☐ No

10e. Street and Number: 29145 Sanderstown Road

10f. Zip Code: 21673

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1942-1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 7 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Mechanic

16b. Kind of Business/Industry: Entreprenur

17. Father's Name *(First, Middle, Last)*: Clark Trippe

18. Mother's Name *(First, Middle, Maiden Surname)*: Mildred Purnell

19a. Informent's Name/Reletionship *(Type, Print)*: Chiquita Warner

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 29149 Sanderstown Road Trappe, Maryland 21673

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, cremetory or other piece)*: Paradise Cemetery | Date: 3/15/2001

20c. Location - City or Town, State: Trappe, Maryland

21. Signature of Funeral Service Licensee: ▶ Janelle C. Henry

22. Name and Address of Facility: Henry Funeral Home P.A. 510 Washington Street Cambridge, Maryland 21613

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediete Cause (Finel disease or condition resulting in death)

a. Respiratory failure — 2 days

Due to (or as a consequence of):

b. subacute cerebella vascular accident — 7-10days

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as e consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary artery disease

congestive heart failure

Drabetes, insulin required

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Wes case referred to medical exeminer? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Panding investigation 6 ☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☑ **Certifying Physician**: To the best of my knowledge, death occurred et the time, dete end piece, end due to the cause(s) and menner es stated. 2 ☐ **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) end menner steted.

29b. Signature end title of certifier: ▶ Haiou Laura Jin

29c. License number: D0055484

29d. Date signed *(Month, Day, Year)*: 0-3-09-2001

30. Nema end eddress of person who completed ceuse of death (Item 23e) (Type, Print): Haiou Laura Jin, M.D., 219 South Washington St., Easton, MD 21601

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 13 2001

32. Registrar's Signetura: ▶ G. Sparks

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

David White

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Division of Vital Records, P.O. Box 68760,**

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09171

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: NORMA JEAN WILSON
2. Date of Death: Month 03 Day 04 Year 2001
3. Time of Death: 16:00
4a. Facility Name *(If not institution, give street and number)*: Memorial Hospital & Medical Center
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

**Funeral Director**

5. Social Security Number: 212-28-2086
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 69 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: MAR.14,1931
9. Birthplace *(State or Foreign Country)*: WEST VIRGINIA

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4017 HAYWOOD AVENUE
10f. Zip Code: 21215
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Data:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): UNKNOWN; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER
16b. Kind of Business/Industry: HOME

17. Father's Name *(First, Middle, Last)*: JOHN HAMRICK
18. Mother's Name *(First, Middle, Maiden Surname)*: ROSETTA KNIGHT

19a. Informant's Name/Relationship *(Type, Print)*: BLANCHE COMER/SISTER-IN-LAW
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 552 MARYLAND STREET, LaVALE, MD 21502

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: SUNSET MEMORIAL PARK
Date: 03/07/2001
20c. Location - City or Town, State: CUMBERLAND, MD

21. Signature of Funeral Service Licensee: Wendy A. Upchurch
22. Name and Address of Facility: UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Coronary Artery Disease — 5 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robustiano J. Barrera MD
29c. License number: D0014865
29d. Date signed *(Month, Day, Year)*: MARCH 7th, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BARRERA, ROBUSTIANO J., M.D., 500 MEMORIAL AVENUE, SUITE 201, CUMBERLAND, MD 21502

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 07 2001
32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

---

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

NORMA WILSON 212-28-2086

4

JLS

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09172

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): KATHLEEN LOUISE WORKENAOUR
2. Date of Death (Month, Day, Year): MARCH 14 2001
3. Time of Death: 7:25 PM
4a. Facility Name (If not institution, give street and number): 13900 LONESOME PINE DRIVE N.E.
4b. City, Town, or Location of Death: FLINTSTONE
4c. County of Death: ALLEGANY

**Funeral Director**

5. Social Security Number: 217-76-9699
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 41 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): DEC 4 1959
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ALLEGANY
10c. City, Town or Location: FLINTSTONE
10d. Inside City Limits: 1☐ Yes 2☒ No
10a. Street and Number: 13900 LONESOME PINE DRIVE N.E.
10f. Zip Code: 21530
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): NURSES AID
16b. Kind of Business/Industry: NURSES AID

17. Father's Name (First, Middle, Last): HERBERT GEORGE TAFT
18. Mother's Name (First, Middle, Maiden Surname): CATHERINE ELEANOR ROMIG

19a. Informant's Name/Relationship (Type, Print): HERBERT GEORGE TAFT FATHER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13900 LONESOME PINE DRIVE N.E. FLINTSTONE MD 21530

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CUMBERLAND CREMATORY
Date: MARCH 15 2001
20c. Location - City or Town, State: CUMBERLAND MARYLAND

21. Signature of Funeral Service Licensee: Dale L. Merritt
22. Name and Address of Facility: MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Endstage Metastatic OVARIA CARCINOMA — 6 mos

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D 22181
29d. Date signed (Month, Day, Year): MARCH 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR GARY L. WAGONER 925 BISHOP WALSH DRIVE CUMBERLAND MARYLAND 21502

**State Registrar**

31. Date filed (Month, Day, Year): MAR 16 2001
32. Registrar's Signature: [signature] G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

CPS
01-1418-043
HAROLD YOST, JR.

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar AMEND ITEM 23a,27 per ME G794 040601 SS

Reg. No. 2001 09173

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

**Physician /Medical Examiner**

**Funeral Director**

To be completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

| | | | | | |
|---|---|---|---|---|---|
| 1. Decedent's Name (First, Middle, Last): Harold W. Yost, Jr. | | | | 2. Date of Death: Month March, Day 13, Year 2001 | 3. Time of Death: 2:30 PM |
| 4a. Facility Name (If not institution, give street and number): 50 Summit Ave. | 4b. City, Town, or Location of Death: Hagerstown | 4c. County of Death: Washington | | | |
| 5. Social Security Number: 236-56-6156 | 6. Sex: 1☒M 2☐F | 7. Age (In yrs. last birthday): 62 Yrs. | If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year): July 15, 1938 | 9. Birthplace (State or Foreign Country): Raleigh, WV |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Washington | Hagerstown | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of Whet Country? |
|---|---|---|
| 50 Summit Ave. | 21740 | U.S.A. |

| 11. Marital Status | 12. Wes Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Rece - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Floor Mechanic | Construction |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Harold W. Yost, Sr. | Mary Ann Hilton Yost |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Harold Yost, Sr. | Box 183 Raleigh, WV 25911 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Blue Ridge Mem. Grdns. | Mar. 17, 2001 | Prosperity, WV |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Dennis A. Bettens | Metropolitan Funeral Service 5517 Vine Street., Alexandria, VA 22310 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such es cardiec or raspiratory errest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as e consequence of): | |
| | d. Due to (or as e consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnency | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal deeth 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contnbuting to death but not resulting in the underlying cause given in Pert I.

| 23e. Did tobecco use contnbute to the cause of deeth? | 24e. Was en eutopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☐No 3☐Probably 4☒Unknown | 1☒Yes 2☐No | 1☒Yes 2☐No |

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) | |
|---|---|---|
| 1☒Yes 2☐No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) SCENE |

| 27. Manner of Death | 28a. Dete of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury et Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rurel Route Number, City or Town, State) |

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and menner es stated.
2☒ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, dete end place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Dete signed (Month, Day, Yaer) |
|---|---|---|
| ▶ Theodore M. Kenoms | OCME | March 14, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
THEODORE Mikng 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 2 6 2001 | ▶ [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

RKD

01-1585-001

SHEILESH ADESHARA

ADMEND ITEM: # 18 PER F.H. G794 4-11-01 WR.

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM 23a,27,28a-f per ME G794 040601 SS

# Certificate of Death

Reg. No. 2001 09174

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|
| Sheilesh Shantilal Adeshara | MARCH | 21, | 2001 | 1:03P. M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 15 IVY STREET | La VALE | ALLEGANY |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 450-57-4898 | 1☒M 2☐F | 47 Yrs. | | | | | JULY 28, 1953 | India |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Allegany | La Vale | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 15 Ivy Street | 21502 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify Asian Indian |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 5 + | Surgeon | Medical |

| 17. Father's Name (First, Middle, Last) | & | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|---|
| Shantilal Adeshara | | TARAMATI SHAH ~~Taramatee~~ ~~UNK.~~ |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Savita Adeshara/Wife | 4029 Legacy Trail Carrollton, TX 75010 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Metro Crematory Inc. | 3-23-01 | Baltimore, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Edward A. Gregorchik | Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. GUNSHOT WOUND OF HEAD | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as e consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnency 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

| 23e. Did tobacco use contribute to the ceuse of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of ceuse of death? |
|---|---|---|
| 1☐Yes 2☒No 3☐Probably 4☐Unknown | 1☒Yes 2☐No | 1☒Yes 2☐No |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) | |
|---|---|---|
| 1☒Yes 2☐No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) SCENE |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☐Natural 2☐Accident 3☒Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | 3-21-01 | found: 1:00 PM | 1☐Yes 2☒No | subject shot himself |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
| | residence | | | 15 Ivy St., Lavale, MD |

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Dennis J Chutero | O.C.M.E. | MARCH 22, 2001 |

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

Dennis Chutero 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 27 2001 | Brenda D Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To be completed by Funeral Director: permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Spoke to F.H. 9/18

90

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 09175

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| Theodore | | Baylor | 03-18-2001 | 6:30 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| STELLA MARIS AT MERCY | BALTIMORE | N/A |

**Funeral Director**

| 5. Social Security Number | 8. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-78-0537 | 1☑M 2☐F | 36 Yrs. | | | 07-31-1964 | MD |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | N/A | BALTIMORE | 1☑Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 517 MT. HOLLY STREET | 21229 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☑Married 3☐Widowed 4☐Divorced | 1☐Yes 2☑No If Yes, Give Year or Dates: | 1☐Yes 2☑No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| GED | N/A | COOK | FOOD SERVICE |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| THEODORE BAYLOR, JR. | BOBBIE L. HOUSE |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| CHERLENE BAYLOR / WIFE | 517 MT. HOLLY STREET, BALTIMORE, MD 21229 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | KING MEMORIAL PARK | 03-23-01 | RANDALLSTOWN, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Vaughn C [illegible] | VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL. PIKE, BALTO. MD. 21229 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Acquired Immunodeficiency Syndrome | |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☑No 3☐Probably 4☐Unknown | 1☐Yes 2☑No | 1☐Yes 2☐No |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☑No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 8☑Other (Specify) Hospice |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

| 29a. Certifier (Check only one) | |
|---|---|
| 1☑ | **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |
| 2☐ | **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [illegible] MD | D40854 | March 19, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David Riseberg 301 St Paul Pl Baltimore 21202

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 27 2001 | ▶ [illegible] |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09176

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Tony S. Bennett
2. Date of Death (Month, Day, Year): 03 18 2001
3. Time of Death: 11:33 AM
4a. Facility Name (If not institution, give street and number): Deaton Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 219-80-6885
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 39 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 09-30-1961
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 916 Chauncey Ave
10f. Zip Code: 21217
10g. Citizen of What Country? USA

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+)
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): James Bennett
18. Mother's Name (First, Middle, Maiden Surname): Margaret E. Jones

19a. Informant's Name/Relationship (Type, Print): Margaret Bennett
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 916 Chauncey Ave. Balto. MD. 21217

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory
Date: 3/22/01
20c. Location - City or Town, State: Balto. MD.

21. Signature of Funeral Service Licensee: ▶ Vaughn C Greene
22. Name and Address of Facility: Vaughn C Greene Funeral Services 5151 Balto. Nat'l Pike Balto. MD. 21229

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. HIV DEMENTIA BY CT
Due to (or as a consequence of):
b. END-STAGE AIDS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CHRONIC RENAL FAILURE, ANAEMIA, HSV-II, S/P CORNEAL TRANSPLANT

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ MD
29c. License number: D52394
29d. Date signed (Month, Day, Year): MARCH 18, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ila Mugasi MD, 29 South Greene Street suite 300, Baltimore MD, 21201

**State Registrar**

31. Date filed (Month, Day, Year): MAR 27 2001
32. Registrar's Signature: ▶ Geneva D Sparks

DHMH 16 Rev 6/95

**To Be Completed by Funeral Director**

BENNETT, TONY
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09177

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): DOROTHY M. BROWN

2. Date of Death: Month MAR Day 24 Year 2001

3. Time of Death: 12:05am

4a. Facility Name (If not institution, give street and number): St. AGNES HEALTH CARE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 219-18-8090

6. Sex: 1☐ M 2☑ F

7. Age (In yrs. last birthday): 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 06-21-1925

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☑ Yes 2☐ No

10e. Street and Number: 4544 MANORVIEW ROAD

10f. Zip Code: 21229

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?: 1☐ Yes 2☑ No. If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12TH GRADE

College (1-4or 5+): 2 YRS

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CLAIMS EXAMINER

16b. Kind of Business/Industry: SOCIAL SECURITY

17. Father's Name (First, Middle, Last): EDWARD BROCKINGTON

18. Mother's Name (First, Middle, Maiden Surname): SADIE SPICER

19a. Informent's Neme/Reletionship (Type, Print): CHARLES BROWN / HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4544 MANORVIEW RD., BALTIMORE, MD 21229

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): GARRISON FOREST

Date: 3/29/01

20c. Location - City or Town, State: OWINGS MILLS, MD

21. Signature of Funeral Service Licensee: ▶ Vaughn C Greene

22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL SERVICE, 5151 BALTO. NAT'L PIKE, BALTO. MD. 21229

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediete Cause (Final diseese or condition resulting in death): a. MYOCARDIAL INFARCTION — 18 HOURS

Due to (or as e consequence of): CORONARY ARTERY DISEASE — 18 YEARS

Sequentially list conditions, If any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

DIABETES MELLITUS.

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings availeble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☑ No

28. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Menner of Death: 1☐ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) end menner steted.

29b. Signeture and title of certifier: ▶ H Quist Kerson M.D.

29c. License number: P14446

29d. Date signed (Month, Day, Year): MARCH 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KARL QUIST-KERSON, St. AGNES HEALTH CARE BALTIMORE MD.

**State Registrar**

31. Date filed (Month, Day, Year): MAR 27 2001

32. Registrar's Signeture: ▶ Barbara G Sparks

ORIGINAL

DHMH 16 Rev 6/95

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

NAME DOROTHY M. BROWN.

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09178

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): William D. Baker
2. Date of Death Month: 3 Day: 23 Year: 2001
3. Time of Death: 1207A
4a. Facility Name (If not institution, give street and number): BON SECOURS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 216-14-7246
6. Sex: 1☑ M 2☐ F
7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10-23-1923
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 2557 W. LAFAYETTE AVENUE
10f. Zip Code: 21216
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH GRADE | College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): POLICE OFFICER
16b. Kind of Business/Industry: BALTO. CITY

17. Father's Name (First, Middle, Last): LAWRENCE BAKER
18. Mother's Name (First, Middle, Maiden Surname): BERDIE LARRY

19a. Informant's Name/Relationship (Type, Print): PAULA BRIGHT / DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1213 N. AUGUSTA AVE., BALTO. MD. 21229

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ARBUTUS CEMETERY
Date: 03-29-01
20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: Vaughn C
22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL' PIKE, BALTO. MD. 21229

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiomyopathy — 15yr
Due to (or as a consequence of):
b. Hypertension — 15yr
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)
Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D26654
29d. Date signed (Month, Day, Year): 3/26/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): YOUNG OH 1412 Crain Hwy N GA GD MD 21061

**State Registrar**

31. Date filed (Month, Day, Year): MAR 27 2001
32. Registrar's Signature: Barbara G Sparks

ORIGINAL

DHMH 16 Rev 6/95

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Physician or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 09179

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Kathy Berry

2. Date of Death Month: March Day: 23 Year: 2001

3. Time of Death: 6:34 PM

4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 214-62-9647

6. Sex: 1☐ M 2☒ F

7. Age (In yrs./last birthday): 47 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10-15-1953

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 33 N. Decker Street

10f. Zip Code: 21224

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Transporter Aid Sturgis

18b. Kind of Business/Industry: City Wide Transportat:

17. Father's Name (First, Middle, Last): Calvin Berry

18. Mother's Name (First, Middle, Maiden Surname): Rebecca Florentine

19a. Informant's Name/Relationship (Type, Print): Donna J. Berry (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 33 N. Decker St. Balto., Md. 21224

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Voshell's Mem. Gardens

Date: 3/29/01

20c. Location - City or Town, State: Dundalk, Maryland

21. Signature of Funeral Service Licensee: Dennis B. Caple

22. Name and Address of Facility: Dennis B. Caple Funeral Home P.A. 4601 York Rd. Balto., Md. 21212

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis — 48 hrs

Due to (or as a consequence of):

b. Spontaneous bacterial peritonitis — 4 days

Due to (or as a consequence of):

c. End stage liver disease — 1 year

Due to (or as a consequence of):

d. Chronic alcohol hepatitis — 20 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Linda Adler, MD

29c. License number: RES-001

29d. Date signed (Month, Day, Year): 3/24/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Linda Adler, MD, 600 N. Wolfe St Tower 110 Baltimore, MD 21287

**State Registrar**

31. Date filed (Month, Day, Year): MAR 2 7 2001

32. Registrar's Signature: G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

01-1657-510
RONALD BOWMAN
JVW

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

*Certificate of Death*

Reg. No. 2001 09180

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Ronald Lee Donte Bowman

2. Date of Death Month Day Year: MARCH 24, 2001

3. Time of Death: 11:40 PM

4a. Facility Name *(If not institution, give street and number)*: REAR OF 1726 NOME STREET

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 215-94-6149

8. Sex: 1☐M 2☐F — X

7. Age *(In yrs. last birthday)*: 23 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Deta of Birth *(Month, Day, Yaer)*: 02-26-1978

9. Birthplece *(Stata or Foraign Country)*: Maryland

Usuel Residence of Decedent

10a. State: Md.

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Insida City Limits: 1☒Yas 2☐No — X

10e. Street and Number: 4418 Marble Hall Road

10f. Zip Code: 21239

10g. Citizen of Whal Country?: USA

11. Marital Status: 1☒Never Married 2☐ Married 3☐Widowed 4☐Divorced — X

12. Was Decedent Evar in U.S. Armed Forces? 1☐Yes 2☒No — X
If Yes, Giva Year or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puerto Rican, atc.)
1☐ Yas 2☒No — X *Specify:*

14. Race - Amarican Indian, Black, Whita, atc. *Specify:* Black

15. Decedent's Education *(Specify only highast grade completed)*
Elementary/Secondary (0-12): 12 th
College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work dona during most of working life. DO NOT use retired)*: Fork LIft Operator

16b. Kind of Businass/Industry: Acco Rubber Company

17. Father's Name *(First, Middle, Last)*: Ronald Howard Bowman

18. Mother's Nama *(First, Middle, Meiden Surneme)*: Felita Denise Crowell

19a. Informant's Name/Relationship *(Type, Print)*: Felita Denise Scott (Mother)

19b. Meiling Addrass *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4547 The Strand Balto., Md. 21215

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)* — X

20b. Place of Disposition *(Neme of cemafary, crematory or othar place)*: King Memorial Park

Data: 3/28/2001

20c. Location - City or Town, Stata: Randallstown, Md.

21. Signature of Funeral Service Licensee: Dennis B. Caple

22. Nama and Address of Facility: Dennis B. Caple Funeral Home P.A. 4601 York Rd. Balto., Md. 21212

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the deeth. Do not entar tha moda of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only ona causa on each lina.

Approximate Interval Between Onsat and Death

Immediate Cause (Final disease or condition resulting in death)
a. Two gunshot wounds of the head and neck
Dua to (or as a consequence of):

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initieted events rasulting in death) Last
b. Dua to (or as a consequence of):
c. Dua to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yas 2☐No 9☐Unknown

23c. If yes, outcoma of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at tima of daath 5☐Othar *(specify)* 9☐Unknown

23d. Deta of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23a. Did tobacco usa contributa to tha causa of death? 1☐Yas 2☒No 3☐Probably 4☐Unknown — X

24a. Was an autopsy performed? 1☒Yas 2☐No — X

24b. Wara autopsy findings available prior to complation of cause of death? 1☒Yes 2☐No — X

25. Was case retarred to medical examiner? XX Yes 2☐No

28. Place of Daath *(Check only ona)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Homa 5☐Rasidance 6☒Othar *(Specify)* SCENE — X

27. Manner of Death: 1☐Natural 2☐Accident 3☐Suicide 4☒Homicide — X 5☐Pending investigetion 6☐Could not be datarmined

28a. Data of Injury *(Month, Day Year)*: 3-24-2001

28b. Tima of Injury: unknown PM

28c. Injury at Work? 1☐Yas 2☒No — X

28d. Describe how injury occurred: subject was shot

28e. Place of Injury - At homa, farm, straat, factory, offica building, etc. *(Specify)*: alley

28f. Location *(Straat and Number or Rural Route Number, City or Town, State)*: 1726 Nome Street Baltimore City, Maryland

29a. Certifier *(Check only one)*
1☐ **Certifying Physician:** To the best of my knowladga, death occurred at tha time, date and placa, and dua to tha causa(s) and mannar es stated.
XX **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurred at tha tima, date and place, and dua to tha cause(s) and mannar stated.

29b. Signature and title of certifier: Lloyd K Mack, M.D.

29c. Licensa number: O.C.M.E.

29d. Data signed *(Month, Day, Year)*: MARCH 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Data filed *(Month, Day, Year)*: MAR 27 2001

32. Registrar's Signature: Anna B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09181

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: LeRoy Brown

2. Date of Death (Month, Day, Year): March 25 2001

3. Time of Death: 1:27 PM

4a. Facility Name *(If not institution, give street and number)*: Sinai Hospital 2401 W. Belvedere Rd

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death:

**Funeral Director**

5. Social Security Number: 217-24-8005

6. Sex: 1 XX M 2 ☐ F

7. Age *(In yrs. last birthday)*: 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 01 09 28

9. Birthplace *(State or Foreign Country)*: M.D.

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: XX Yes 2 ☐ No

10e. Street and Number: 4002 Ayrdale Ave

10f. Zip Code: 21215

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Reca - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th grade; College (1-4or 5+): 4 yrs

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Tech Electronic

16b. Kind of Business/Industry: Beth Steel

17. Father's Name *(First, Middle, Last)*: Frank Henley

18. Mother's Name *(First, Middle, Meiden Surname)*: Ethel Inez Brown

19a. Informent's Name/Relationship *(Type, Print)*: Mary Brown-Wife

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 4002 Ayrdale Ave, Baltimore Md 21215

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: GarrisonnForest Vet.

Date: 3/28/01

20c. Location - City or Town, State: Owings Mills, Md

21. Signature of Funeral Service Licensee: John B. Johnson Jr.

22. Neme end Address of Facility: March F/H West 4300 Wabash Ave, Baltimore, Md 21215

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Causa (Final disease or condition resulting in death)

a. Intracranial Haemorhge. — 1 HR

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

b. Hypertension. — Many years.

Due to (or as a consequenca of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the causa of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of causa of death? 1 ☐ Yes 2 ☐ No

25. Was casa referred to medical examiner? 1 ☑ Yes 2 ☐ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☐ Netural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☑ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and manner es stated. 2 ☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated.

29b. Signeture and title of certifier: Tariq Khan

29c. License number: D21730

29d. Date signed *(Month, Day, Year)*: 3.25.2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TARIQ KHAN Sinai Hospital. Baltimore.

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 27 2001

32. Registrar's Signature: Geneva G. Sparks

ORIGINAL

DHMH 16 Rev 6/95

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Pt known as Leroy Brown

01-1577-510
crn
Jerry Brown

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM: #16B PER F.H. G693 3-27-01 WR

# Certificate of Death

Reg. No. 2001 09182

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|
| Jerry | Brown Sr. | March | 21 | 2001 | 10:00 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 269 McCurley Street | Baltimore | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year Months | Days | If Under 24 Hrs. Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 229-52-7343 | XX M 2☐ F | 59 Yrs. | | | | | 03 18 42 | V.A. |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | NA | Baltimore | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 269 McCurley Street | 21229 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married XX Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementery/Secondery (0-12) | College (1-4or 5+) | | |
| 10th grade | na | Supervisor | ~~Montenello Rehab~~ MONTEBELLO REHAB CENTER |

| 17. Father's Neme (First, Middle, Last) | 18. Mother's Name (First, Middle, Meiden Surneme) |
|---|---|
| Duke Cummings | Elnore Brown |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Daughter Mary Ann Brown Jackson | 1019 Woodson Road, Baltimore Md 21212 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | King Memorial Park | 3/27/01 | Randallstown, Md |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| John B. Johnson Jr. | March F/H West 4300 Wabash Ave, Baltimore, Md 21215 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

| | | Approximate Interval Between Onset end Death |
|---|---|---|
| Immediate Cause (Finel disease or condition resulting in death) | a. Coronary Thrombosis | |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last | b. Arteriosclerotic Cardiovascular Disease | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Data of delivery Month Day Year |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal deeth 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown | |

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

Diabetes Mellitus

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of ceuse of death? |
|---|---|---|
| 1☐ Yes 2☐ No 3☐ Probebly 4☒ Unknown | 1☒ Yes 2☐ No | 1☒ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) | |
|---|---|---|
| 1☒ Yes 2☐ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☒ Other (Specify) at scene |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of injury M | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.
2☒ Medical Examinar: On the basis of exeminetion and/or investigation, in my opinion, deeth occurred et the time, dete and place, end due to the ceuse(s) end manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Dennis J. Chute M.D. | O.C.M.E. | March 22, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis Chute M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Yeer) | 32. Registrar's Signature |
|---|---|
| MAR 2 7 2001 | G. Sparks |

10

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

**To Be Completed by Funeral Director**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09183

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): James Williams Bartlett, Jr.

2. Date of Death: Month March Day 24, Year 2001

3. Time of Death: 6:30 AM

4a. Facility Name (If not institution, give street and number): 814 Broadwater Way

4b. City, Town, or Location of Death: Gibson Island

4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 235-32-0132

6. Sex: 1☐M 2☐F

7. Age (In yrs. last birthday): 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): FEB 2, 1926

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Gibson Island

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 814 Broadwater Way

10f. Zip Code: 21056

10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: 1942-1945

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 5 +

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Physician

16b. Kind of Business/Industry: University of Rochester

17. Father's Name (First, Middle, Last): James Williams Bartlett

18. Mother's Name (First, Middle, Maiden Surname): Margaret Alexander

19a. Informant's Name/Relationship (Type, Print): Nancy Bartlett/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 814 Broadwater Way Gibson Island, MD 21056

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Inc.

Date: 3-26-01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Thomas Gregor

22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. MULTIPLE MYELOMA — 9 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D29373

29d. Date signed (Month, Day, Year): 3/26/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ERIC J. SEIFTER 10755 FALLS RD, SUITE 200 LUTHERVILLE, MD 21093

**State Registrar**

31. Date filed (Month, Day, Year): MAR 27 2001

32. Registrar's Signature

ORIGINAL

DHMH 16 Rev 6/95

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 09184

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| ANNA EVA BRYANT | MARCH 21, 2001 | 9:43 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| ANNE ARUNDEL MEDICAL CENTER | ANNAPOLIS | ANNE ARUNDEL |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 100-18-6545 | 1☐M 2☒F | 74 Yrs. | | | JUNE 16, 1926 | MARYLAND |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | ANNE ARUNDEL | CROWNSVILLE | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1115 OAKVIEW DRIVE | 21032 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 10 | | HOMEMAKER | OWN HOME |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| ROBERT EDWARD MOESTA | EVA KATHLEEN HAASE |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| MR. RICHARD BRYANT (HUSBAND) | 1115 OAKVIEW DRIVE, CROWNSVILLE, MARYLAND 21032 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | GLEN HAVEN MEMORIAL PARK | 3/24/2001 | GLEN BURNIE, MD. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ R. Stan Hyka | SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Septic shock | |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Pneumonia | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☒No |

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Aimee Yu | D55187 | March 21, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Aimee Yu 64 Franklin Street, Annapolis, MD 21401

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 27 2001 | ▶ Deputy D Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Physician or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09185

Beatty, Dolores

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): DOLORES JOAN BEATTY

2. Date of Death: Month March Day 20 Year 2001

3. Time of Death: 5:20 p.m.

4a. Facility Name (If not institution, give street and number): North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 218-26-8097

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 69 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MARCH 28, 1931

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: MILLERSVILLE

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 244 SEVERN ROAD

10f. Zip Code: 21108

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): NURSE AID

16b. Kind of Business/Industry: HOSPITAL

17. Father's Name (First, Middle, Last): CHARLES BUCKLEY

18. Mother's Name (First, Middle, Maiden Surname): ELEANOR TROTT

19a. Informant's Name/Relationship (Type, Print): JAMES D. BEATTY, II (HUSBAND)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 244 SEVERN ROAD, MILLERSVILLE, MARYLAND 21108

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): CHESAPEAKE CREMATION CENTER, LLC.

Date: 3/24/2001

20c. Location - City or Town, State: STEVENSVILLE, MD.

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such aa cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. INTERSTITAL PULMONARY FIBROSIS

Due to (or as a consequence of):

b. HYPERTENSION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner ateted.

29b. Signature and title of certifier: MD

29c. License number: D43977

29d. Date signed (Month, Day, Year): March 20 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Arden Greenup 301 Hospital Drive, Glen Burnie, MD 21061

**State Registrar**

31. Date filed (Month, Day, Year): MAR 27 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

01-1618-510
GARY BEACH
ASP

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar AMEND ITEM 23a,27,28a-f per ME G794-041101 SS

Reg. No. 2001 09186

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|
| Gary | Beach | MARCH 20 2001 | 4:18 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| GOOD SAMARITAN HOSPITAL | BALTIMORE | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 306-56-6344 | 1 [X] M 2 [ ] F | 46 Yrs. | | | OCT 22, 1954 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | N/A | Baltimore | 1 [X] Yes 2 [ ] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 6401 Loch Raven Blvd. | 21239 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced | 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: | 1 [ ] Yes 2 [X] No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 11 | | Laborer | Construction |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Bill Beach | Jacqueline Dvorak |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Jacqueline Hernandez/Mother | 6401 Loch Raven Blvd. Baltimore, MD 21239 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Metro Crematory Inc. | 3-26-01 | Baltimore, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Thomas Gregor | Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | e. ACUTE ETHANOL AND NARCOTIC INTOXICATION | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1 [ ] Yes 2 [X] No 9 [ ] Unknown | 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 [X] Yes 2 [ ] No | 1 [X] Yes 2 [ ] No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 [X] Yes 2 [ ] No | Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [X] Could not be determined | found: 3-16-01 | found 9:00 PM | 1 [ ] Yes 2 [X] No | unknown |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| found in van | 2920 Overland Ave., Balto., MD |

29a. Certifier (Check only one)

1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Dennis J Chutero | O.C.M.E | MARCH 24, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis Chutero 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 27 2001 | Jeanne G. Sparks |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Amended Item#7 perFHG793 3/27/2001 EW

# Certificate of Death

2001 09187
Reg. No.

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Daniel Brown

2. Date of Death Month: March Day: 19 Year: 2001

3. Time of Death: 7:p.m.

4a. Facility Name (If not institution, give street and number): Lawn Green Nursing Home

4b. City, Town, or Location of Death: Balto.

4c. County of Death: N/A.

**Funeral Director**

5. Social Security Number: 217-03-98-66

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): ~~84~~ 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): October 26, 1913

9. Birthplace (State or Foreign Country): S.C.

Usual Residence of Decedent

10a. State: MD. | 10b. County: N/A | 10c. City, Town or Location: Balto. | 10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 1728 E. Lafayette Ave | 10f. Zip Code: 21213 | 10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th grade | College (1-4or 5+): NO

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Steel Worker

16b. Kind of Business/Industry: Armco Steel

17. Father's Name (First, Middle, Last): William Brown

18. Mother's Name (First, Middle, Maiden Surname): Mamie Grady

19a. Informant's Name/Relationship (Type, Print): Ruby Hice daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1241 Silverthorne Rd. Balto. MD. 21239

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MD. Nat. Mem. Pk. | Date: 3-23-01

20c. Location - City or Town, State: Laurel MD.

21. Signature of Funeral Service Licensee: Patricia Bett

22. Name and Address of Facility: Betts Funeral Home 1125 N. Caroline St. Balto. MD. 21213

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Gangrene of lower extremity — weeks

Due to (or as a consequence of):
b. Peripheral Vascular Disease — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Dementia, prostate Cancer, Chronic obstructive lung Disease

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1 ☐ Yes 2 ☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D17718

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**State Registrar**

31. Date filed (Month, Day, Year): MAR 27 2001

32. Registrar's Signature: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM 29c,30 per phys G793 032701 SS

# Certificate of Death

Reg. No. 2001 09188

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): LUCILLE G. BEARDS
2. Date of Death (Month, Day, Year): MARCH 3, 2001
3. Time of Death: 10:30 AM
4a. Facility Name (If not institution, give street and number): 343 Green Street
4b. City, Town, or Location of Death: Havre de Grace
4c. County of Death: Harford

**Funeral Director**

5. Social Security Number: 052-18-4581
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Apr 3, 1909
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: MD
10b. County: Harford
10c. City, Town or Location: Havre de Grace
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 343 Green Street
10f. Zip Code: 21078
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker
16b. Kind of Business/Industry: none

17. Father's Name (First, Middle, Last): Max Goldmeyer
18. Mother's Name (First, Middle, Maiden Surname): Theresa Obler

19a. Informant's Name/Relationship (Type, Print): Richard Beards/son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): Box 68 Kirkwood, PA 17536

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place)
Date
20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: ▶ Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Myocardial Infarction | 1 month |
| Due to (or as a consequence of): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. | Atherosclerosis | 15 years |
| Due to (or as a consequence of): | | |
| c. | | |
| Due to (or as a consequence of): | | |
| d. | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic obstructive Pulmonary disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶
29c. License number: D36715
29d. Date signed (Month, Day, Year): 03-13-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Sherif Osman- 39 Churchville Road, BelAir 21014

**State Registrar**

31. Date filed (Month, Day, Year): MAR 27 2001
32. Registrar's Signature: ▶ Jeanne G Sparks

DHMH 16 Rev 6/95

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29c
30

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09189

JEAN M. BIRCH
Baltimore, Maryland 21215-0020

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): JEAN M. BIRCH
2. Date of Death (Month, Day, Year): MARCH 25, 2001
3. Time of Death: 3:10 P.M.
4a. Facility Name (If not institution, give street and number): DULANEY TOWSON NURSING HOME
4b. City, Town, or Location of Death: TOWSON
4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 215-22-1138
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11/11/1926
9. Birthplace (State or Foreign Country): PENNSYLVANIA

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1925 WADSWORTH WAY
10f. Zip Code: 21239
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH GRADE | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TELEPHONE OPERATOR
16b. Kind of Business/Industry: PHONE CO.

17. Father's Name (First, Middle, Last): RAYMOND E. CANNON
18. Mother's Name (First, Middle, Maiden Surname): ELIZABETH GALLAGHER

19a. Informant's Name/Relationship (Type, Print): WILLIAM BIRCH SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4918 TARTAN HILL RD. PERRY HALL, MD 21128

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): NEW CATHEDRAL CEMETERY
Date: 3/29/01
20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Coronary Artery Disease | 5Years |
| Due to (or as a consequence of): b. | Peripheral Vascular Disease | 5Years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c. | | |
| Due to (or as a consequence of): d. | | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Attending Physician
29c. License number: D53642
29d. Date signed (Month, Day, Year): March 26 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): XAQ2404 3007 E Northern Parkway Baltimore 21214

**State Registrar**

31. Date filed (Month, Day, Year): MAR 2 7 2001
32. Registrar's Signature: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09190

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): NICOLE F. BROWN

2. Data of Deeth: Month March Day 21 Yaar 2001

3. Time of Death: 2:12 AM

4e. Fecility Nama (If not institution, giva streat and number): Harbor Hospital

4b. City, Town, or Location of Daeth: Baltimore

4c. County of Death: N/A

**Funeral Director**

5. Social Sacurity Number: n/a

6. Sax: 1☐ M 2☒ F

7. Age (In yrs. last birthday): Yrs.

If Under 1 Year: Months; Days: 19

If Under 24 Hrs.: Hours; Min.

8. Deta of Birth (Month, Day, Year): March 02 2001

9. Birthplaca (Stata or Foreign Country): Maryland

Usual Rasidanca of Decedant

10a. State: Md.

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Insida City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 137 Birckhead Street

10f. Zip Coda: 21230

10g. Citizan of What Country?: USA

11. Marital Status: 1☒ Navar Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Dacadant Ever in U.S. Armad Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas: X

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1☐ Yes 2☒ No Specify:

14. Raca - Amarican Indian, Black, White, etc. Specify: white

15. Decedant's Education (Specify only highast grada completed)

Elamantary/Secondary (0-12): n/a

Collega (1-4or 5+): 0

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired): n/a

16b. Kind of Businass/Industry: n/a

17. Father's Neme (First, Middla, Last): Joseph Brown

18. Mothar's Nama (First, Middle, Maiden Surnama): Catherine Cohen

19a. Informent's Name/Ralationship (Type, Print): Joesph Brown (Father)

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 137 Birckhead Street, Baltimore, Md. 21230

20a. Mathod of Disposition: 1☐ Buriel 2☒ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Other (Specify)

20b. Placa of Disposition (Nama of cemetary, cramatory or othar placa): Green Mount Cemetery

Data: 3/22/2001

20c. Location - City or Town, State: Baltimore, MD.

21. Signeture of Funeral Service Licensee: [signature]

22. Nama and Addrass of Facility: McCully-Polyniak Funeral Home P.A. 130 E. Fort ave. Baltimore, Md. 21230

**Physician /Medical Examiner**

23a. Part I. Enter tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart feilure. List only ona cause on aach line.

Approximata Intarval Batween Onset and Death

Immediate Causa (Final disaasa or condition resulting in daath)

a. Enterobacter Cloacae Septicemia — 24 hours

Dua to (or es e consequance of):

Sequentially list conditions, if any, leading to immadiata causa. Entar Underlying Causa (Diseesa or Injury thet initieted evants rasulting in daath) Lest

b.

Due to (or es e consequanca of):

c.

Dua to (or as a consequanca of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa givan in Part I.: Prematurity - 28 weeks gestation

23b. Did tobacco use contributa to the causa of death? 1☐ Yas 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Wara autopsy findings availabla prior to compiation of cause of daath? 1☐ Yas 2☒ No

25. Was casa refarrad to medical examinar? 1☐ Yes 2☒ No

26. Piece of Daeth (Chack only ona)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Homa 5☐ Rasidanca 6☐ Othar (Specify)

27. Manner of Deeth: 1☒ Natural 2☐ Accident 3☐ Sulcida 4☐ Homicida 5☐ Pending invastigation 6☐ Could not ba determined

28a. Data of Injury (Month, Day Year)

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Placa of Injury - At homa, farm, straet, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Cartifiar (Check only one): 1☒ **Certifying Physician:** To tha best of my knowledge, daath occurred at tha time, dete and place, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and piace, and dua to tha cause(s) and mannar stated.

29b. Signetura and title of certifiar: Laurel G. Yap, M.D.

29c. License number: D 29003

29d. Data signed (Month, Day, Year): March 21, 2001

30. Nama and addrass of person who completed cause of daath (Item 23a) (Type, Print): LAUREL G. YAP, M.D. 3001 South Hanover St. Baltimore, MD 21225

**State Registrar**

31. Dete filed (Month, Day, Year): MAR 27 2001

32. Registrar's Signatura: [signature]

DHMH 16 Rev 6/95

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 09191

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| James Franklin Barrett, Sr. | March 26, 2001 | 1:45 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 625 Tampa Road | Essex | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-14-2531 | 1☒M 2☐F | 78 Yrs. | | | Jan. 25,1923 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Essex | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 625 Tampa Road | 21221 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: WWII | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 4 Years | | Exterminator | Pest Control |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| William Eugene Barrett | Claudie O'Donnell |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mrs. Betty Jo Barrett (Wife) | 625 Tampa Road Essex, Maryland 21221 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Holly Hill Mem. Gdns. | 3/29/2001 | Middle River, MD |

21. Signature of Funeral Service Licensee: Dan C. Caudell

22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Colon CA | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): Laryngeal cancer | |
| | c. Due to (or as a consequence of): Heart failure | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☐No 3☐Probably 4☐Unknown | 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one) 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Ritha Checa M.D | D0054802 | 03/26/2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ritha Chca M.D 107 Beacon Road Balto. Md 21220

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 27 2001 | |

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 09192

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Lester O. Brooks Jr.

2. Date of Death: Month March, Day 23, Year 2001

3. Time of Death: 12:37 A.M.

4a. Facility Name *(If not institution, give street and number)*: North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 212 01 0071

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 89 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: August 10,1911

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Pasadena

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 480 Riverside Drive

10f. Zip Code: 21122

10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 4th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Cabinet Maker

16b. Kind of Business/Industry: Baird Seating Company

17. Father's Name *(First, Middle, Last)*: Lester O. Brooks Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Clara Meyers

19a. Informant's Name/Relationship *(Type, Print)*: Donald Brooks / Brother

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8805 Stoneridge Circle 103 Baltimore, Maryland 21208

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Olivet Cemetery

Date: 3/29/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Donna M Zgamiousha

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | MYOCARDIAL INFARCTION | 1 DAY |
| Due to (or as a consequence of): b. | ESSENTIAL HYPERTENSION | 18YEARS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c. | CHRONIC OBSTRUCTIVE PULMONARY DISEASE | 15YEARS |
| d. | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE
HYPOTHYROIDISM
SENILE DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Harjit Singh MD

29c. License number: D 14160

29d. Date signed *(Month, Day, Year)*: March 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Harjit Singh, M.D. 5410-A Ritchie Highway Baltimore, Maryland 21225

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 27 2001

32. Registrar's Signature: Gene D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed without undue delay after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 09193

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): EDWARD WHITE BUFFINGTON
2. Date of Death: Month March Day 25th Year 2001
3. Time of Death: 2:15 AM
4a. Facility Name (If not institution, give street and number): Carroll County General Hospital
4b. City, Town, or Location of Death: Westminster
4c. County of Death: Carroll

**Funeral Director**

5. Social Security Number: 215-07-8380
8. Sex: XX M 2☐ F
7. Age (In yrs. last birthday): 97 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 05-10-1903
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD.
10b. County: CARROLL
10c. City, Town or Location: SYKESVILLE
10d. Inside City Limits: 1☐ Yes XX No
10e. Street and Number: 7200 3RD. AVENUE
10f. Zip Code: 21784
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married XX Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? XX Yes 2☐ No If Yes, Give Year or Dates: 1943-1945
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes XX No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 4 YEARS
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CORPORATE OFFICER
18b. Kind of Business/Industry: U.S.F.& G.

17. Father's Name (First, Middle, Last): JOHN J. BUFFINGTON
18. Mother's Name (First, Middle, Maiden Surname): LEILA TALBOT

19a. Informant's Name/Relationship (Type, Print): BARBARA BUFFINGTON RUTHERFORD (DAUGH.)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 244 WILLOW LAKE DRIVE, AIKEN, S.C. 29803

20a. Method of Disposition: XX Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GREEN MOUNT CEMETERY
Date: 3-28-01
20c. Location - City or Town, State: BALTO., MD., 21202

21. Signature of Funeral Service Licensee: R. A. Ruth
22. Name and Address of Facility: HENRY W. JENKINS AND SONS COMPANY 6500 YORK ROAD, BALTIMORE, MARYLAND, 21212

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Sepsis
Due to (or as a consequence of):
Approximate Interval Between Onset and Death: Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D48006
29d. Date signed (Month, Day, Year): March 25th, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KOFI BOAITEY, 200 Memorial Ave, Westminster, MD 21157

**State Registrar**

31. Date filed (Month, Day, Year): MAR 27 2001
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Edward W. Buffington
88
10

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09194

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Antonia Ann Bush
2. Date of Death (Month, Day, Year): March 21, 2001
3. Time of Death: 11:00 PM
4a. Facility Name (If not institution, give street and number): 201 River Way Court
4b. City, Town, or Location of Death: Owings Mills
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 103-24-9844
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 69 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug 18, 1931
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Owings Mills
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 201 River Way Court
10f. Zip Code: 21117
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sales
16b. Kind of Business/Industry: Retail Store
17. Father's Name (First, Middle, Last): George Geannecos
18. Mother's Name (First, Middle, Maiden Surname): Tillieante Manolakos
19a. Informant's Name/Relationship (Type, Print): Francis O. Bush Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 201 River Way Court Owings Mills, MD 21117
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MD Veterans Cemetery
Date: 3/28/01
20c. Location - City or Town, State: Garrison, Maryland
21. Signature of Funeral Service Licensee: ▶ Stephen M Jenkins
22. Name and Address of Facility: Eline Funeral Home 11824 Reisterstown Road Reisterstown, MD 21136

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Breast Cancer — 3 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Metastases to lung and liver

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶
29c. License number: D27123
29d. Date signed (Month, Day, Year): 3/23/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Judith M. Hoover 250 Main ST Reisterstown MD 21136

**State Registrar**

31. Date filed (Month, Day, Year): MAR 2 7 2001
32. Registrar's Signature: ▶ Geneva G Sparks

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

2001 09195
Reg. No.

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Hilda Barksdale
2. Data of Death: Month March Day 20 Yaar 2001
3. Time of Daath: 1:55 PM
4a. Facility Nama (If not institution, give street and number): Caton Manor Nursing Home
4b. City, Town, or Location of Daath: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 216-58-0421
6. Sex: 1☐ M 2☒ F
7. Aga (In yrs. last birthday): 100 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Yaar): May 5, 1900
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Insida City Limits: 1☒ Yas 2☐ No
10e. Street and Number: 2311 W. Lafayette Ave.
10f. Zip Coda: 21216
10g. Citizen of Whal Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Giva Yaer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:
14. Race - Amarican Indian, Black, Whita, atc. Specify: African American

15. Decedent's Education (Specify only highast grade completed): Elementary/Secondary (0-12): 10 College (1-4or 5+): 8
16a. Dacedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa retired): Homemaker
18b. Kind of Businass/Industry: Own Home

17. Father's Name (First, Middle, Last): unk.
18. Mother's Name (First, Middle, Maiden Sumame): unk.

19a. Informant's Name/Relationship (Type, Print): (Friend) Ms. Karin Schley
19b. Mailing Address (Straet and Number or Rural Route Number, City or Town, State, Zip Coda): 711 N. Monroe St. Balto. Md. 21217

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Nama of cematary, cramatory or othar place): Greenmount Crematory Date: 3/28/2001
20c. Location - Clty or Town, Stata: Balto. Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ
22. Nama and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not antar the moda of dying, such as cardiac or respiratory errast, shock, or heart failura. List only ona causa on each lina.

Immediate Cause (Finel disease or condition resulting in death): a. Ischemic Heart Disease
Approximata Interval Batwean Onsat and Death: Unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Dua to (or as a consequance of):
c. Dua to (or as a consequance of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yas, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of daath 5☐ Othar (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not rasulting in the undarlying causa given in Part I.
Hypertension
Dementia

23a. Did tobacco usa contributa to tha causa of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown
24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Wara autopsy findings availabla prior to completion of ceuse of daath? 1☐ Yes 2☐ No

25. Was cese relerred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Chack only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Othar: 4☒ Nursing Homa 5☐ Rasidance 8☐ Othar (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be datarmined
28a. Date of Injury (Month, Day Yaar)
28b. Tima of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28a. Place of Injury - At home, farm, straat, factory, office building, etc. (Specify)
28f. Location (Street and Numbar or Rurel Routa Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To tha best of my knowledga, daath occurred at tha tima, date and place, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of axamination and/or investigation, in my opinion, daath occurrad at tha tima, data and place, and dua to tha ceusa(s) and manner stated.
29b. Signature and title of certifier: MD
29c. Licensa numbar: D27564
29d. Data signed (Month, Day, Yaar): 3/27/01

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): Allen Hettleman 1838 Greene Tree Rd 21208

**State Registrar**

31. Data filed (Month, Day, Yaar): MAR 27 2001
32. Registrar's Signature: Brenda G. Sparks

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification; To Be Completed by Physician/Medical Examiner**

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 09196

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| MATTHEW L. BAULER | March 25, 2001 | 9:45 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| UNION MEMORIAL HOSPITAL | BALTIMORE | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 219-18-0956 | 1 [X] M 2 [ ] F | 75 Yrs. | | | JUNE 11, 1925 | MARYLAND |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD. | BALTIMORE | JOPPA | 1 [ ] Yes 2 [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of Whet Country? |
|---|---|---|
| 361 ENFIELD ROAD | 21085 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indien, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: | 1 [ ] Yes 2 [X] No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 9 | | CONSTABLE | STATE OF MARYLAND |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Neme (First, Middle, Maiden Sumame) |
|---|---|
| MATTHEW BAULER | HILDA WEINER |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) |
|---|---|
| MATTHEW J. BAULER/ SON | 361 ENFIELD ROAD, JOPPA, MARYLAND 21085 |

| 20a. Method of Disposition | 20b. Piece of Disposition (Neme of cemetery, cremetory or other piece) | Dete | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | HOLY REDEEMER | 3/29/01 | BALTIMORE, MARYLAND |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] | LILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD. 21231 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Metastatic Colon Cancer | Three Months |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as e consequence of): | |
| | d. Due to (or as e consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnency | 23d. Dete of delivery Month Day Year |
|---|---|---|
| 1 [ ] Yes 2 [ ] No 9 [ ] Unknown | 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnency 4 [ ] Pregnant et time of death 5 [ ] Other (specify) 9 [ ] Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 [ ] Yes 2 [X] No | 1 [ ] Yes 2 [X] No |

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one)

Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

| 28a. Dete of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury et Work? 1 [ ] Yes 2 [ ] No | 28d. Describe how injury occurred |
|---|---|---|---|
| | | | |

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) end menner es stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) end manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Yeer) |
|---|---|---|
| ▶ Mark Levis MD | D0052391 | March 25, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mark Levis Union Memorial Hospital Department of Medicine 201 East University Parkway, Baltimore

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 27 2001 | ▶ [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09197

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): SANDRA COMEGYS
2. Data of Death — Month: MARCH Day: 16 Year: 2001
3. Time of Death: 1150p
4a. Facility Name (If not institution, give street and number): Irvington Knolls
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 237-78-2888
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 51 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 6/28/1949
9. Birthplace (State or Foreign Country): NC

Usual Residance of Decedent

10a. Steta: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 13 S Gilmore St.
10f. Zip Code: 21223
10g. Citizen of Whet Country?: USA

11. Meritei Stetus: 1☐ Nevar Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No — If Yas, Giva Yaar or Datas:
13. Was Dacedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 1☐ Yas 2☒ No Specify:
14. Race - American Indien, Bleck, Whita, atc. Specify: Black

15. Decedent's Education (Specify only highast grada compiatad) — Elamantary/Secondary (0-12): 11th — College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired): Domestic
16b. Kind of Businass/Industry: Housewife

17. Fathar's Nama (First, Middla, Last): James W. Wilson
18. Mother's Name (First, Middla, Maiden Surnama): Dorothy Johnson

19a. Informant's Name/Relationship (Type, Print): Betty Bryd
19b. Mailing Address (Straet and Number or Rural Route Number, City or Town, Stata, Zip Code): 1022 S. Vance St. Sanford, NC 27330

20a. Mathod of Disposition: 1☐ Buriel 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)
20b. Piece of Disposition (Name of cematary, cramatory or other place): Womack Cemetery
Data: 3/23/01
20c. Location - City or Town, Stata: Sandford, NC

21. Signature of Funaral Service Licensaa: Vaughn C Greene
22. Nama and Addrass of Facility: Vaughn C Greene Funeral Svc. 5151 Balto. Nat'l Pike Balto. MD. 21229

**To Be Completed by Funeral Director**

**Physician /Medical Examiner**

23a. Part1. Entar tha diseasa, or complications that caused tha daath. Do not antar tha moda of dying, such es cardiac or raspiratory arrast, shock, or haart feilura. List only one causa on aach lina.

Approximeta Intarval Batween Onset and Death

Immediate Cause (Finai diseesa or condition resulting in death): a. Cancer of lung with progressive mets to brain
Due to (or as a consequanca of):

Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disease or Injury that initiated avants resulting in daath) Last:
b. Due to (or as a consequance of):
c. Due to (or as a consequanca of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Wara autopsy findings available prior to completion of causa of daath? 1☐ Yas 2☐ No

25. Was casa raferred to medical axaminer? 1☐ Yas 2☒ No

26. Placa of Death (Check only one): Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA — Othar: 4☒ Nursing Home 5☐ Residance 6☐ Othar (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding investigation 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Yaar)
28b. Tima of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28e. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Phyeician:** To tha best of my knowledge, daath occurrad at the time, date and place, and due to the causa(s) and mannar as stated. 2☐ **Medical Examinar:** On tha basis of examination and/or investigation, in my opinion, daath occurred at tha tima, date and place, and dua to tha causa(s) and mannar stated.

29b. Signatura end titla of certifier: A Ahmed MD
29c. Licansa number: D39127
29d. Data signed (Month, Day, Year): 3/17/01

30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print): A. AHMED 821 N. Eutaw Street Baltimore MD 21201

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**State Registrar**

31. Date filed (Month, Day, Year): MAR 27 2001
32. Registrar's Signatura: Barbara A Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

*Certificate of Death*

Reg. No. 2001 09198

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Eugene T. Clayton

2. Date of Death Month: MARCH Day: 24 Year: 2001

3. Time of Death: 0205a M.

4a. Facility Name *(If not institution, give street and number)*: Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 212-56-4868

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 49 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: NOV 22, 1951

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 3410 Chestnut Avenue

10f. Zip Code: 21211

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Carpenter

18b. Kind of Business/Industry: Construction

17. Father's Name *(First, Middle, Last)*: George L. Clayton

18. Mother's Name *(First, Middle, Maiden Surname)*: Marjorie Thompson

19a. Informant's Name/Relationship *(Type, Print)*: Linda Bloom/Sister

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3139 Hollins Ferry Road Baltimore, MD 21227

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory Inc.

Date: 3-26-01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Thomas Gregor

22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION — 60 MIN

Due to (or as a consequence of):

b. ACIDOSIS — 8 HOURS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. SEPSIS — 24 HOURS

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other *(specify)* 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

PERIPHERAL VASCULAR DISEASE

CORONARY ARTERY DISEASE

HEMORRHAGE, MESENTERIC ISCHEMIA

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: AT2438946

29d. Date signed *(Month, Day, Year)*: MARCH 24 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KRISHN M. SHARMA 201 E. UNIVERSITY PKWY BALTIMORE MD 21218

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 27 2001

32. Registrar's Signature: Brenda B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 09199

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|
| Anna M Cyrier | March 24 2001 | 11:00AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Riverview Nursing Center | Essex | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-40-0541 | 1☐ M 2☒ F | 89 Yrs. | | | June 5 1911 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Baltimore | Essex | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 411 Dorsey Ave. | 21221 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8th | | Homemaker | own home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Frank Drescher | Agnes Plewacki |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Agnes Crabbs/daughter | 411 Dorsey Ave. Baltimore MD 21221 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) / Date | 20c. Location - City or Town, State |
|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Sacred Heart of Jesus 3/30/01 | Baltimore MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ R. Terry Connelly | Connelly Funeral Home of Essex 300 Mace Ave. Baltimore MD 21221 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Pneumonia Bacterial | 1 wk |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. Coronary artery disease | > 5 yrs |
| | Due to (or as a consequence of): c. Hypertension | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery (Month, Day, Year) |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown | 1☐ Yes 2☐ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one)
1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Khan MD | D 25391 | 3-26-2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KHAN - 5601 - Loch Raven Blvd Baltimore MD 21239

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 27 2001 | ▶ Geneva G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

---

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 09200

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

**Funeral Director**

**To Be Completed by Funeral Director**

| | | | | |
|---|---|---|---|---|
| 1. Decedent's Name (First, Middle, Last): Mildred L. Curtis | | | 2. Date of Death Month Day Year: March 23 2001 | 3. Time of Death: 8:15 AM |
| 4a. Facility Name (If not institution, give street and number): 946 E. Piney Hill Rd | 4b. City, Town, or Location of Death: Monkton | | 4c. County of Death: Baltimore | |
| 5. Social Security Number: 212-20-7807 | 6. Sex: 1☐M 2☒F | 7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year): Oct 21 1926 |
| 9. Birthplace (State or Foreign Country): Virginia | | | | |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md | Baltimore | Monkton | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 946 E. Piney Hill Rd | 21111 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | Self employed | artist |
| 2 | — | | |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Peter J. Thacker | Dollie M. Simms |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Patricia Burgess | 21299 Dunk Freeland Rd. Parkton, Md 21120 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Poplar Grove Meth Cem | March 26 2001 | Timonium Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Kristal L Wells | Evans Funeral Chapel 8800 Harford Rd. Baltimore, Md 21234 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Myocardial infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown | 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | 23d. Date of delivery Month Day Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

- Severe COPD
- Respiratory failure

| 23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown | |
|---|---|
| 24a. Was an autopsy performed? 1☐Yes 2☒No | 24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? 1☐Yes 2☒No | 26. Place of Death (Check only one) Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 8☐Other (Specify) |
|---|---|

| 27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1☐Yes 2☐No | 28d. Describe how injury occurred |
|---|---|---|---|---|
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] MD | D12732 | 3/26/2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. George Bedon 515 Fairmont Ave. Towson, Md

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 27 2001 | [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 09201

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Emily W. Callis
2. Date of Death Month Day Year: March 26 2001
3. Time of Death: 7 PM
4a. Facility Name (If not institution, give street and number): 3621 Putty Hill Ave.
4b. City, Town, or Location of Death: Parkville
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 213-03-5630
8. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 92 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept 1 1908
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Parkville
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 3621 Putty Hill Ave.
10f. Zip Code: 21234
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elamentary/Secondary (0-12): — Collega (1-4or 5+): —
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): laundry depart.
18b. Kind of Business/Industry: Baltimore Towel

17. Father's Name (First, Middle, Last): — Foresight
18. Mother's Name (First, Middle, Maiden Surname): unknown

19a. Informant's Name/Relationship (Type/Print): Howard A. Callis
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3621 Putty Hill Ave. Baltimore Md 21234

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens of Faith
Date: March 29 2001
20c. Location - City or Town, State: Rosedale Maryland

21. Signature of Funeral Service Licensee: Krista L. Wells
22. Name and Address of Facility: Evans Funeral Chapel 8800 Harford Rd Baltimore, Md 21234

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Arteriosclerotic Cardio Vascular Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fatal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the causa of death? 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No
24b. Were autopsy findings available prior to complation of cause of death? 1 ☐ Yas 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Mannar of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicida 4 ☐ Homicide 5 ☐ Panding investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. 2 ☒ Medical Examinar: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, data and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: Charles F O'Donnell MD
29c. License number: D-09383
29d. Date signed (Month, Day, Year): March 26, 2001

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): Charles F O'Donnell MD 11 Hamlet Hill Rd Baltimore MD 21210

**State Registrar**

31. Date filed (Month, Day, Year): MAR 27 2001
32. Registrar's Signature: Jeanne D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To be Completed by Funeral Director

To be Completed by Physician/Medical Examiner

Medical Certification;

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 09202

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): DARLENE H. CHRISTENSON
2. Date of Death Month: MARCH Day: 25 Year: 2001
3. Time of Death: 3:15 AM
4a. Facility Name (If not institution, give street and number): 204 KIMARY Ct #1B
4b. City, Town, or Location of Death: Forest Hill
4c. County of Death: HARFORD

**Funeral Director**

5. Social Security Number: 528-24-1882
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 74 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN 6, 1927
9. Birthplace (State or Foreign Country): UTAH

Usual Residence of Decedent

10a. State: MD
10b. County: HARFORD
10c. City, Town or Location: Forest Hill
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 204 KIMARY Ct #1B
10f. Zip Code: 21050
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): self employed
16b. Kind of Business/Industry: Artist

17. Father's Name (First, Middle, Last): ARCHIE F. HADLOCK
18. Mother's Name (First, Middle, Maiden Surname): SELMA FROST

19a. Informant's Name/Relationship (Type, Print): Pat Walsh daugh.
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 292B Canterbury Rd Bel Air Md 21014

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): EVANS FUNERAL Chapel Bel Air Date: MARCH 26, 2001
20c. Location - City or Town, State: Forest Hill, Md

21. Signature of Funeral Service Licensee: Linda S. Wells
22. Name and Address of Facility: EVANS FUNERAL Chapel 3 Newport DR, Forest Hill, Md 21050

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. chronic obstructive pulmonary disease
Due to (or as a consequence of): b.
Due to (or as a consequence of): c.
Due to (or as a consequence of): d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death:

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: David S. Dunn
29c. License number: D32299
29d. Date signed (Month, Day, Year): MARCH 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID S. DUNN 115 West Mac Phail

**State Registrar**

31. Date filed (Month, Day, Year): MAR 27 2001
32. Registrar's Signature: Linda S Sparks

DHMH 17 Rev 1/2001

ORIGINAL

---

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Amend Item#10b perFHG793 3/27/2001 EW

# Certificate of Death

Reg. No. 2001 09203

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: William R Catlin

2. Date of Death: Month March Day 24 Year 2001

3. Time of Death: 5:41 PM

4a. Facility Name *(If not institution, give street and number)*: NORTHWEST

4b. City, Town, or Location of Death: RANDALLSTOWN

4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 188-20-4567

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 71 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JUNE 11, 1929

9. Birthplace *(State or Foreign Country)*: PA

Usual Residence of Decedent

10a. State: MD

10b. County: ~~BALTIMORE~~

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4002 DORCHESTER RD

10f. Zip Code: 21207

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: PURCHASING AGENT

16b. Kind of Business/Industry: AUTO

17. Father's Name *(First, Middle, Last)*: HAYES CATLIN

18. Mother's Name *(First, Middle, Maiden Surname)*: LOTTIE MAE BUTLER

19a. Informant's Name/Relationship *(Type, Print)*: MARY CATLIN/WIFE

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4002 DORCHESTER RD., BALTO., MD 21207

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: CROWNSVILLE VET CEM

Date: 3/28/01

20c. Location - City or Town, State: CROWNSVILLE, MD

21. Signature of Funeral Service Licensee: James A. Morton

22. Name and Address of Facility: JAMES A. MORTON & SONS F.H., INC 1701 LAURENS ST. BALTO., MD. 21207

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ M/D IVSur

29c. License number: M43974

29d. Date signed *(Month, Day, Year)*: March 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M/D IVSurg - Northwest Hospital Randallstown, MD

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 27 2001

32. Registrar's Signature: ▶ Geneva G Sparks

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09204

Cook, Hardy

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

**Funeral Director**

**To Be Completed by Funeral Director**

1. Decedent's Name (First, Middle, Last): HARDY MERRILL COOK, JR.

2. Date of Death: Month MARCH Day 25 Year 2001

3. Time of Death: 12:30pm

4a. Facility Name (If not institution, give street and number): SINAI HOSPITAL of BALTIMORE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

5. Social Security Number: 112-07-1876

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 84 Yrs.

If Under 1 Year: Months ____ Days ____

If Under 24 Hrs.: Hours ____ Min. ____

8. Date of Birth (Month, Day, Year): 7/20/1916

9. Birthplace (State or Foreign Country): NEW YORK

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: BALDWIN

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 9 MANOR KNOLL COURT

10f. Zip Code: 21030

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 4 YEARS

College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ENGINEER

16b. Kind of Business/Industry: WESTERN ELECTRIC CO.

17. Father's Name (First, Middle, Last): HARDY M. COOK, SR.

18. Mother's Name (First, Middle, Maiden Surname): MARGARET MORGAN

19a. Informant's Name/Relationship (Type, Print): HARDY M. COOK, III SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7505 CITADEL DR. COLLEGE PARK, MD 20740

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MORELAND MEMORIAL PARK

Date: 3/29/01

20c. Location - City or Town, State: HILLENDALE, MD

21. Signature of Funeral Service Licensee: Heather N. Hay

22. Name and Address of Facility: THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. MYOCARDIAL INFARCTION.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. ____

Due to (or as a consequence of):

c. ____

Due to (or as a consequence of):

d. ____

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

ATRIAL FIBRILLATION

Congestive Heart failure

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: PHYSICIAN

29c. License number: D0054558

29d. Data signed (Month, Day, Year): MARCH 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FREDERICK BURKE, JR, MD 2401 W. Belvedere Ave BALTIMORE, MD 21215

**State Registrar**

31. Data filed (Month, Day, Year): MAR 27 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09205

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Mary Helen Cullum
2. Date of Death: Month March Day 24, Year 2001
3. Time of Death: 6:45 pm
4a. Facility Name (If not institution, give street and number): Genesis Eldercare - Heritage Center
4b. City, Town, or Location of Death: Dundalk
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 215-30-1102
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 68 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 10, 1933
9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 221 Detriot Avenue
10f. Zip Code: 21222
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 yrs. College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Machine Operator
16b. Kind of Business/Industry: Paper

17. Father's Name (First, Middle, Last): Harry German
18. Mother's Name (First, Middle, Maiden Surname): Marie Tragesar

19a. Informant's Name/Relationship (Type, Print): Carl Cullum Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 221 Detriot Avenue, Dundalk, Md. 21222

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Oaklawn Cemetery
Date: March 28, 2001
20c. Location - City or Town, State: Dundalk, Md.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Rd. Dundalk, Md. 21222

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. CEREBROVASCULAR ACCIDENT — 8 DAYS
Due to (or as a consequence of):
b. CEREBRAL ANEURYSM — 9 YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. ESSENTIAL HYPERTENSION. — 53 YEARS
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] M.D.
29c. License number: D14160
29d. Date signed (Month, Day, Year): March 24, 2001
30. Name and address of person who completed cause of death (Item 29a) (Type, Print): HARJIT SINGH M.D. 5110-A RITCHIE HIGHWAY, BALTIMORE, MARYLAND 21225

**State Registrar**

31. Date filed (Month, Day, Year): MAR 27 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0020**

**Division of Vital Records, P.O. Box 68760,**

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 09206

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| ANTHONY K. CASON | MARCH 17, 2001 | 12:48 pm M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| HOWARD COUNTY GENERAL HOSPITAL | COLUMBIA | HOWARD |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-51-0282 | 1[X] M 2[ ] F | 2 Yrs. | | | 4-6-1998 | MARYLAND |

**Usual Residence of Decedent**

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD. | HOWARD | COLUMBIA | 1[X] Yes 2[ ] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 8947 TAMAR DR. APT.202 | 21045 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1[X] Never Married 2[ ] Married 3[ ] Widowed 4[ ] Divorced | 1[ ] Yes 2[X] No If Yes, Give Year or Dates: | 1[ ] Yes 2[X] No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| -0- | -0- | N/A | N/A |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| GREGORY CASON | SHANTA M. SHARPE |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| SHANTA M. SHARPE (MOTHER) | 8947 TAMAR DR. APT.202 COLUMBIA, MARYLAND 21044 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1[ ] Burial 2[X] Cremation 3[ ] Removal from State 4[ ] Donation 5[ ] Other (Specify) | METRO CREMATORY | 3-24-2001 | BALTIMORE, MARYLAND |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Sarah D. Hurn | PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration Pneumonia

Due to (or as a consequence of):

b. Viral Gastroenteritis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Metachromatic Leukodystrophy

Due to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1[ ] Yes 2[ ] No 9[ ] Unknown | 23c. If yes, outcome of pregnancy 1[ ] Live birth 2[ ] Fetal death 3[ ] Ectopic pregnancy 4[ ] Pregnant at time of death 5[ ] Other (specify) 9[ ] Unknown | 23d. Date of delivery Month Day Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1[ ] Yes 2[X] No 3[ ] Probably 4[ ] Unknown

| 24a. Was an autopsy performed? 1[X] Yes 2[ ] No | 24b. Were autopsy findings available prior to completion of cause of death? 1[ ] Yes 2[X] No |
|---|---|

| 25. Was case referred to medical examiner? 1[X] Yes 2[ ] No | 26. Place of Death (Check only one) Hospital: 1[ ] Inpatient 2[X] ER/Outpatient 3[ ] DOA Other: 4[ ] Nursing Home 5[ ] Residence 6[ ] Other (Specify) |
|---|---|

**Medical Certification; To Be Completed by Physician/Medical Examiner**

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1[X] Natural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined | | M | 1[ ] Yes 2[ ] No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1[X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2[ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Henri F. Merrick, MD | D34745 | 3/24/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Henri F. Merrick 10630 Little Patuxent Pkwy #325 Columbia MD 21044

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 27 2001 | ▶ Brenda G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

01-1257-510
crn
Kelvin Anthony Drake

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09207

1- State Registrar

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| KELVIN DRAKE | March 06 2001 | 12:43 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| University of Maryland Medical Center | Baltimore | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-06-0559 | 1☑M 2☐F | 33 Yrs. | | | 06-21-1967 | VA |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | N/A | BALTIMORE | 1☑Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 910 NORTH ROSEDALE STREET | 21229 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☑Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☐Yes 2☑No If Yes, Give Year or Dates: | 1☐Yes 2☑No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 11 TH GRADE | N/A | LABORER | CONSTRUCTION |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| RICHARD CRIM | JEANETTE DRAKE |

| 19a. Informant's Name/Relationship (Type, Print) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|---|
| JEANETTE TURNER | MOTHER | 910 N. ROSEDALE ST., BALTO. MD. 21216 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | KING MEMORIAL PARK | 3-13-01 | RANDALLSTOWN, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Vaughn C [illegible] | VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL. PIKE, BALTO. MD. 21229 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. GUNSHOT WOUND OF CHEST | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fatal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24e. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☒Yes 2☐No | 1☒Yes 2☐No |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☒Yes 2☐No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☐Natural 2☐Accident 3☐Suicide 4☒Homicide 5☐Pending investigation 6☐Could not be determined | 3/6/01 | 0004 M | 1☐Yes 2☒No | SUBJECT WAS SHOT |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| PLAYGROUND | 700 Block LONGWOOD ST, BALTIMORE MD |

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | O.C.M.E. | March 07, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mary G. Ripple MD 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 2 7 2001 | ▶ [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Physician or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

2001 09208 Reg. No.

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| FLOYD R. DAVIS, SR. | MARCH 23 2001 | 5:48 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| ST. AGNES HOSPITAL | BALTIMORE | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 228-01-8503 | 1☑M 2☐F | 83 Yrs. | | | 02-06-1918 | VA |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | N/A | BALTIMORE | 1☑Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1917 HILLSIDE DRIVE | 21207 | USA |

| 11. Marital Status | 12. Wes Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☑Married 3☐Widowed 4☐Divorced | 1☐Yes 2☑No If Yes, Give Year or Dates: | 1☐Yes 2☑No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12TH GRADE | N/A | STEEL WORKER | BETHLEHEM STEEL |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| ASHTON DAVIS | GRACIE GOODE |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| MARY DAVIS \| WIFE | 1917 HILLSIDE DR., BALTO. MD. 21207 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | MD. NATL CEMETERY | 03-28-01 | LAUREL, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Vaughn C [illegible] | VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL PIKE, BALTO. MD. 21229 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Arrhythmia due to ASCVD | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Prostate Cancer

Osteoporosis

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☐No 3☐Probably 4☒Unknown | 1☒Yes 2☐No | 1☐Yes 2☒No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☒Yes 2☐No | Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ MD | P12582 | MARCH 23 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARY MICHAEL CANTWELL 900 CATON AVE BALTIMORE MD 21228

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 27 2001 | ▶ [signature] |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME DAVIS, FLOYD R.

DHMH 17 Rev 1/2001

MAR 2 9 2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 09209

Michael Daniels

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): MICHAEL L. DANIELS

2. Date of Death Month Day Year: MARCH 24, 2001

3. Time of Death: 3:30pm M

4a. Facility Name (If not institution, give street and number): RAVENWOOD NURSING CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: NA

**Funeral Director**

5. Social Security Number: 212-80-7653

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 42 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): SEPT. 14, 1958

9. Birthplace (State or Foreign Country): MD

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 1640 ELLAMONT AVENUE

10f. Zip Code: 21216

10g. Citizen of What Country: USA

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: AFRICAN AMERICAN

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+): NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SALESMAN

18b. Kind of Business/Industry: SHOE COMPANY

17. Father's Name (First, Middle, Last): ARCHER DANIELS

18. Mother's Name (First, Middle, Meiden Surname): EDNA DANIELS

19a. Informant's Name/Relationship (Type, Print): ARCHER DANIELS (FATHER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1640 N. ELLAMONT STREET BALTIMORE, MD 21216

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): WOODLAWN CEMETERY

Date: 3/30/01

20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: WYLIE FUNERAL HOME PA 638 N. GILMOR STREET BALTIMORE, MD 21217

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. END STAGE AUTO/IMMUNE DEFICIENCY DISORDER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as e consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Dey Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one) Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☐Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D24100

29d. Date signed (Month, Day, Year): 3-27-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M. L. Prabhakar MD 300 Arasmy Place Suite 4A. BAL, MD.

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

2

**State Registrar**

31. Date filed (Month, Dey, Year): MAR 2 7 2001

32. Registrar's Signature: [signature] for G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

AMEND ITEMS #23b&cPER PHY G798 8/27/01 JH

Reg. No. 2001 09210

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): KATHRYN S. DAVIS

2. Date of Death: Month February Day 26 Year 2001

3. Time of Death: 01:35 AM

4a. Facility Name (If not institution, give street and number): Suburban Hospital

4b. City, Town, or Location of Death: Bethesda,

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 410-24-7746

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 13, 1920

9. Birthplace (State or Foreign Country): Tennessee

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 12402 Village Square West

10f. Zip Code: 20852

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Child Psychologist

16b. Kind of Business/Industry: Psychology

17. Father's Name (First, Middle, Last): George M. Saunders

18. Mother's Name (First, Middle, Maiden Surname): Ada Johnson

19a. Informant's Name/Relationship (Type, Print): Virginia S. Gatling

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7504 Nottoway Place, Springfield, Virginia 22150

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): National Crematory

Date: Feb. 27, 2001

20c. Location - City or Town, State: Falls Church, Va.

21. Signature of Funeral Service Licensee: Bruce L. Booberg

22. Name and Address of Facility: DEMAINE FUNERAL HOME FSL 520 S. Washington St. Alexandria, VA

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. INTERCEREBRAL BLEEDING

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. HYPERTENSION

Due to (or as a consequence of):

c. CAD/ ARTERIOSCLEROSIS

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Penelope Friedman MD

29c. License number: D0051271

29d. Date signed (Month, Day, Year): 2/26/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Penelope Friedman, M.D. 5401 Western Avenue, N.W., Washington, D.C. 20015

**State Registrar**

31. Date filed (Month, Day, Year): MAR 0 1 2001

32. Registrar's Signature: Penny P. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

P.G. CR (10)

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09211

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): JAMES E. DUNMIRE

2. Date of Death (Month Day Year): MARCH 18, 2001

3. Time of Death: 1836

4a. Facility Name (If not Institution, give street and number): 305 PHELPS AVENUE

4b. City, Town, or Location of Death: GLEN BURNIE

4c. County of Death: ANNE ARUNDEL

**Funeral Director**

5. Social Security Number: 175-24-9760

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): OCT. 20, 1930

9. Birthplace (State or Foreign Country): PENNSYLVANIA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: GLEN BURNIE

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 305 PHELPS AVENUE

10f. Zip Code: 21060

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No. If Yes, Give Year or Dates: 1948-1951

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): OWNER

16b. Kind of Business/Industry: TAVERN

17. Father's Name (First, Middle, Last): FLOYD N. DUNMIRE

18. Mother's Neme (First, Middle, Maiden Surname): NANCY McCOY

19a. Informant's Neme/Reletionship (Type, Print): PATRICIA CROUSE (DAUGHTER)

19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 33 GAMBRILLS ROAD, SEVERN, MARYLAND 21144

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Piece of Disposition (Name of cemetery, crematory or other place): MARYLAND VETERANS CEMETERY Date: 3/22/2001

20c. Location - City or Town, Stata: CROWNSVILLE, MD.

21. Signature of Funeral Service Licensee: Paul D. Hagan

22. Name and Address of Facility: SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onsat and Death

Immediate Cause (Final disease or condition resulting in death): a. Arteriosclerotic Heart Disease — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: William P. Jones MD Deputy

29c. License number: D 06054

29d. Data signad (Month, Day, Year): 3/21/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William P. Jones, MD 695 America 21035

**State Registrar**

31. Data filed (Month, Day, Year): MAR 27 2001

32. Registrar's Signature: Lenora G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled-in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 09212

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ALBERT J. DAVIS
2. Date of Death Month Day Year: MARCH 20, 2001
3. Time of Death: 1:40 P.M.
4a. Facility Name (If not institution, give street and number): GILCREST HOSPICE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 214-38-9940
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 63 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 9-25-37
9. Birthplace (State or Foreign Country): N.C.

Usual Residence of Decedent

10a. State: Md.
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3406 Woodstock AVE
10f. Zip Code: 21213
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 5T; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TRUCK DRIVER
16b. Kind of Business/Industry: Baltimore Capitol Coop

17. Father's Name (First, Middle, Last): JIMMY DAVIS
18. Mother's Name (First, Middle, Maiden Surname): AMANDA WILLIAMS

19a. Informant's Name/Relationship (Type, Print): Alatha DAVIS / Spouse
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3406 Woodstock Ave - Balto, MD 21213

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mooreland Cemetery
Date: 3/24/01
20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: Lynette Cromatie
22. Name and Address of Facility: Betts Funeral Home 1129 N. Caroline ST - Balto, MD. 21213

**Physician /Medical Examiner**

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Lung Cancer — Approximate Interval: 6 months
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Hospice

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier: W. Anthony Riley, MD
29c. License number: D25205
29d. Date signed (Month, Day, Yaar): March 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W.A. Riley GBMC 6701 N. Charles St. Balto. Md 21204

**State Registrar**

31. Date filed (Month, Day, Year): MAR 27 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 09213

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): MARY KATHERINE DUGINSKE

2. Date of Death (Month, Day, Year): MARCH 26, 2001

3. Time of Death: 506 AM

4a. Facility Name (If not institution, give street and number): Stella Maris @ Mercy

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 397-52-4228

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 49 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): October 7, 1951

9. Birthplace (State or Foreign Country): Wisconsin

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 926 Stubblefield Lane

10f. Zip Code: 21202

10g. Citizen of What Country?: USA

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Librarian

18b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): Donald Joseph Duginske

18. Mother's Name (First, Middle, Maiden Surname): Virginia Mary Kollmer

19a. Informant's Name/Relationship (Type, Print): Pamela E. Doster POA

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 233 East Heath Street Baltimore, Maryland 21230

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Greenmount Cemetery

Date: 3/28/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Dennis Stephen Kenakes

22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Adenocarcinoma - unknown Primary

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one)

Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) HOSPICE

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier: ▶ DR MD

29c. License number: D 40854

29d. Date signed (Month, Day, Year): MARCH 26, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): DAVID RISEBERG 301 ST PAUL PL BALTIMORE, MD 21202

**State Registrar**

31. Date filed (Month, Day, Year): MAR 2 7 2001

32. Registrar's Signature: Brenda B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification; To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09214

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): GREGORY GEORGE DUDOK
2. Date of Death (Month, Day, Year): March 25, 2001
3. Time of Death: 11:20 pm
4a. Facility Name (If not institution, give street and number): 4513 WHITE MARSH ROAD
4b. City, Town, or Location of Death: WHITE MARSH
4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 216-32-9134
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 65 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 19, 1936
9. Birthplace (State or Foreign Country): UKRAINE

Usual Residence of Decedent

10a. State: MD.
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 3101 O'DONNELL STREET
10f. Zip Code: 21224
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1957-59
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LABORER
16b. Kind of Business/Industry: PREMIER SEATING CO.

17. Father's Name (First, Middle, Last): MICHAEL DUDOK
18. Mother's Name (First, Middle, Maiden Surname): KATERYNA BOHONIS

19a. Informent's Name/Relationship (Type, Print): NATALIE DUDOK/ DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3024 OVERLAND AVE., BALTIMORE, MARYLAND 21214

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ST. MICHAELS UKRAINIAN | Date: 3/29
20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: LILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD. 21231

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. Malignant Melanoma (metastatic) — 20 mo.
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☒ Other (Specify) SISTERS HOME

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Deborah A Frassica, MD
29c. License number: D0052496
29d. Date signed (Month, Day, Year): 3/27/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DEBORAH A. FRASSICA 10753 Falls Rd Ste 145, Lutherville, MD 21093

**State Registrar**

31. Date filed (Month, Day, Year): MAR 27 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09215

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Emma S. Dickson

2. Date of Death Month: March Day: 24 Year: 2001

3. Time of Death: 6:30 p.m.

4a. Facility Name *(If not institution, give street and number)*: Maryland General Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 218 42 3822

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 57 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 19, 1944

9. Birthplace *(State or Foreign Country)*: North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2312 Cedley Street

10f. Zip Code: 21230

10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Packer

16b. Kind of Business/Industry: Glass

17. Father's Name *(First, Middle, Last)*: James Ray

18. Mother's Name *(First, Middle, Maiden Surname)*: Marjorie Goddfrey

19a. Informant's Name/Relationship *(Type, Print)*: Marjorie McGuire / Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 427 Rogers Avenue Glen Burnie, Maryland 21060

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Cedar Hill Cemetery

Date: 3/26/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Shannon Liggett

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. End stage renal disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Respiratory Failure

Due to (or as a consequence of):

c. Anemia

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Modika, Ndolamvu

29c. License number: 89367

29d. Date signed *(Month, Day, Year)*: 3/21/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ndolamvu Badika MD c/o Mayland General Hospital

**State Registrar**

31. Date Filed *(Month, Day, Year)*: MAR 27 2001

32. Registrar's Signature: G. Sparks

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Emma Dickson
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09216

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): HARRY J. ELLIS SR.

2. Date of Death (Month, Day, Year): MARCH 25, 2001

3. Time of Death: 1:00 pm

4a. Facility Name (If not institution, give street and number): HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: n/a

**Funeral Director**

5. Social Security Number: 220-05-3003

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 92 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 09 1908

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: Anne Arundel Co.

10c. City, Town or Location: Glen Burnie

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 26 McGuirk Drive

10f. Zip Code: 21061

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 5

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver

16b. Kind of Business/Industry: Freight Company

17. Father's Name (First, Middle, Last): Charles Ellis

18. Mother's Name (First, Middle, Maiden Surname): Shalie Reed

19a. Informant's Name/Relationship (Type, Print): Mark J. Ellis (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 26 McGuirk Drive, Glen Burnie, Md. 21061

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Glen Haven Memorial Park

Date: 3/29/2001

20c. Location - City or Town, State: Glen Burnie, Md.

21. Signature of Funeral Service Licensee: George M. Hampton Jr.

22. Name and Address of Facility: McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Md. 21122

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SQUAMOUS CELL CANCER-PAROTID GLAND — 4 MONTHS

Due to (or as a consequence of):

b. URINARY TRACT INFECTION — 1 WEEK

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE

ATRIAL FIBRILLATION

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one)

Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rishi Sawhney

29c. License number: RES-000

29d. Date signed (Month, Day, Year): MARCH 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RISHI SAWHNEY, MD HARBOR HOSPITAL 3001 S. HANOVER ST. BALTIMORE, MD 21225

**State Registrar**

31. Date filed (Month, Day, Year): MAR 27 2001

32. Registrar's Signature

ORIGINAL

DHMH 16 Rev 6/95

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09217

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Dwight Finch
2. Date of Death: Month 3 Day 17 Year 01
3. Time of Death: 4 05 AM
4a. Facility Name (If not institution, give street and number): Bon Secours Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 214-78-0939
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 39 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 1, 1961
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 1827 Eagle St.
10f. Zip Code: 21223
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 10th Grade
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Edward McGee

17. Father's Name (First, Middle, Last): Willard Finch
18. Mother's Name (First, Middle, Maiden Surname): Eldora Freeman

19a. Informant's Name/Relationship (Type, Print): Eldora Finch - mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21223: 1827 Eagle St. Baltimore, Maryland

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion Cemetery
Date: 3/22
20c. Location - City or Town, State: Landsdowne, Maryland

21. Signature of Funeral Service Licensee: Kevin Parker
22. Name and Address of Facility: Kevin A. Parker Funeral Home 3512 Frederick Ave. Baltimore, MD. 21229

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. ANOXIC ENCEPHALOPATHY
Due to (or as a consequence of):
b. SEIZURE DISORDER
Due to (or as a consequence of):
c. END STAGE AIDS
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one)
Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D24100
29d. Date signed (Month, Day, Year): 03-17-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M.L. PRABHAKAR MD 300 ARMORY PLACE BAL, MD

**State Registrar**

31. Date filed (Month, Day, Year): MAR 27 2001
32. Registrar's Signature: Barbara G Sparks

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Finch, Dwight
Baltimore, Maryland 21215-0020

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Amend Item#10e perFHG793 3/27/2001 EW

# Certificate of Death

Reg. No. 2001 09218

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Bernard D Frazier
2. Data of Death — Month: March Day: 23, Year: 2001
3. Tima of Death: 12:35Am
4a Facility Name (If not institution, giva street and number): VA Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A.

**Funeral Director**

5. Social Security Number: 219-03-1871
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 86 Yrs.
If Under 1 Year — Months: Days:
If Under 24 Hrs. — Hours: Min.:
8. Data of Birth (Month, Day, Year): July 3, 1914
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD,
10b. County: N/A.
10c. City, Town or Location: BALTO.
10d. Inside City Limits: 1 [X] Yas 2 [ ] No
10e. Street and Number: 1012 E. E 20th St,
10f. Zip Code: 21218
10g. Citizen of What Country?: U.S.A

11. Marital Status: 1 [ ] Nevar Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yas 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1 [ ] Yes 2 [X] No Specify:
14. Raca - American Indian, Black, White, atc. Specify: Black

15. Decedent's Education (Specify only highest grada completed)
Elementary/Secondary (0-12): 10 grade
College (1-4or 5+): NO
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Balto. City
16b. Kind of Business/Industry: Cleaning Buildings

17. Father's Nama (First, Middle, Last): William Frazier
18. Mother's Name (First, Middle, Maiden Sumama): Ella Fletcher

19a. Informant's Name/Reletionship (Type, Print): Marion Jordon
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code): 1401 N. Lakewood Ave Balto. MD. 21213

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from Stata 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Nama of cemetery, crematory or other place): Garrison Forest V.A. Date: 3-28-01
20c. Location - City or Town, Stata: Owings Mills MD.

21. Signature of Funeral Service Licensee: Patricia Bitte
22. Nama and Addrass of Facility: Betts Funeral Home 1124 N. Caroline St. Balto. md 21213

**Physician /Medical Examiner**

23a. Part1. Entar tha disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only ona cause on aach lina.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immedieta Cause (Final disease or condition resulting in death) a. | Pulmonary edema | 72 hours |
| Due to (or as a consequence of): | | |
| b. | renal failure | 72 hours |
| Sequentially list conditions, If any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c. | | |
| Dua to (or as a consequence of): d. | | |

Part II. **Other aignificant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Congestive heart failure
Prostate cancer

23b. Did tobacco usa contributa to the causa of death? 1 [ ] Yaa 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No
24b. Wara autopsy findings available prior to compiation of causa of death? 1 [ ] Yas 2 [ ] No

25. Was case referred to medical examinar? 1 [ ] Yas 2 [X] No

26. Place of Death (Check only one)
Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Homa 5 [ ] Residanca 6 [ ] Othar (Specify)

27. Mannar of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Pending investigation 6 [ ] Could not be datarmined
28a. Data of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yas 2 [ ] No
28d. Describe how injury occurred
28a. Plece of Injury - At home, farm, street, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To tha best of my knowledge, death occurred at the time, date and place, and due to tha cause(s) and mannar as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Nicole Thobe, MD
29c. License number: P14656
29d. Data signed (Month, Day, Year): March 23, 2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): Nicole Thobe, 10 N. Greene St. Baltimore, MD 21201

**State Registrar**

31. Data filed (Month, Day, Year): MAR 27 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

219-03-1871

2N

10+1 VA

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09219

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Adrian Henry Feigh

2. Date of Death: Month: March; Day: 22; Year: 01

3. Time of Death: 12:02 PM

4a. Facility Name (If not institution, give street and number): Levindale Nursing Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 217-03-9889

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Year: Months: ; Days:

If Under 24 Hrs.: Hours: ; Min.:

8. Date of Birth (Month, Day, Year): June 6, 1918

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 513 E. 41st Street

10f. Zip Code: 21218

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1941-1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 10

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Food Manager

16b. Kind of Business/Industry: Retail

17. Father's Name (First, Middle, Last): Joseph Elmer Feigh

18. Mother's Name (First, Middle, Maiden Surname): Marie Catherine Johnston

19a. Informant's Name/Relationship (Type, Print): Anna Mae Feigh (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 513 E. 41st Street Baltimore, Maryland 21218

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery

Date: 3/26/01

20c. Location - City or Town, State: Parkville, Maryland

21. Signature of Funeral Service Licensee: ▶ Steven T. Bittle

22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Throat Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the causes of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medicel examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one): Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year):

28b. Time of Injury: M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mennar es stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and piece, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: ▶ Raymond Miller MD

29c. License number: D47683

29d. Date signed (Month, Day, Year): 3/22/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Raymond Miller 25 Main Street Suite 203 Reisterstown MD

**State Registrar**

31. Date filed (Month, Day, Year): MAR 27 2001

32. Registrar's Signature: ▶ Steve G Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Adrian Feigh

3/16/01 11:40AM

June Ferrara

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

2001 09220
Reg. No.

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| JUNE B. FERRARA | MARCH 16 2001 | 11:40am |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| GILCHRIST CENTER | TOWSON | BALTIMORE |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 146-20-6692 | 1☐M 2☒F | 72 Yrs. | | | 07/17/1928 | NEW YORK |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| ME. | N/A | WELLS | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 100 PORT RD. | 04090 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12YRS | | HOUSEWIFE | HOMEMAKER |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| VINCENT A. GILL | EVELYN MENARD |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| NANCY WILLIAMS | 14216 SAWMILL CT. PHOENIX, MD. 21131. |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☐Cremation 3☒Removal from State 4☐Donation 5☐Other (Specify) | HILLSIDE CEMETERY | MARCH 23 2001 | SCOTCH PLAINS, N.J. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ R. H. Runt | HENRY W. JENKINS AND SONS COMPANY 6500 YORK ROAD, BALTIMORE, MARYLAND, 21212 |

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Lung cancer | 9 months |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Data of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnent at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☒Yes 2☐No 3☐Probably 4☐Unknown | 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) Hospice |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ H. Anthony Riley, MD | D25205 | March 16, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
W. A. Riley GBMC 6701 N. Charles St. Balto. md 21204

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

15

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 27 2001 | Brenda G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09221

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): John H. Ford

2. Date of Death: Month MARCH Day 21 Year 2001

3. Time of Death: 04:34

4a. Facility Name (If not institution, give street and number): ST AGNES HEALTHCARE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 229-18-7191

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 2, 1921

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 2219 Windsor Ave.

10f. Zip Code: 21216

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Afro American

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 3 College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer

16b. Kind of Business/Industry: Calvert Construction Co.

17. Father's Name (First, Middle, Last): Simon Ford

18. Mother's Name (First, Middle, Maiden Surname): Annie Hunter

19a. Informent's Name/Relationship (Type, Print): Mrs. Irene Ford (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2219 Windsor Ave. Balto. Md. 21216

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion

Date: 3/28/2001

20c. Location - City or Town, State: Lansdowne, Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ

22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION — 1 DAY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

BACTEREMIA

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Appeal MD

29c. License number: 14445

29d. Date signed (Month, Day, Year): MARCH, 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LOUISA APPEH-DANQUAH, 900 CATON AVE, BALTIMORE MD

**State Registrar**

31. Date filed (Month, Day, Year): MAR 2 7 2001

32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

NAME JOHN H FORD

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

Amend Item 25 per ME - For State Registrar 03/27/01dhbG893

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09222

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Lamont Ford

2. Date of Death Month Day Year: February 21, 2001

3. Time of Death: 5:15 P M

4a. Facility Name (If not institution, give street and number): University of Maryland

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

**Funeral Director**

5. Social Security Number: 219 80 7992

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 39 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10/28/61

9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD.

10b. County:

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 830 LAKEWOOD AVE.

10f. Zip Code: 21205

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: AFRO AMERICAN

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): COOK

18b. Kind of Business/Industry: ESSEX C.C.

17. Father's Name (First, Middle, Last): MARION FORD

18. Mother's Name (First, Middle, Maiden Surname): CATHERINE FORD

19a. Informant's Name/Relationship (Type, Print): SHEILA FORD

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2504 E. CHASE ST. BALTO. MD. 21213

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MT. ZION

Date: 2/26/01

20c. Location - City or Town, State: LANSDOWNE, MD.

21. Signature of Funeral Service Licensee: Paul A Estep

22. Name and Address of Facility: ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PL. BALTO. MD. 21217

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. PROBABLE RUPTURED AORTIC ANEURYSM

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Data of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

**Medical Certification; To Be Completed by Physician/Medical Examiner**

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☒ No

28. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residenca 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J M. Titus

29c. License number: OCME

29d. Date signed (Month, Day, Year): MARCH 27, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JACK M. TITUS M.D. Deputy Chief Medical Examiner 111 Penn St - Balto MD 21201

**State Registrar**

31. Date filed (Month, Day, Year): MAR 2 7 2001

32. Registrar's Signature: Brenda G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar ADMEND ITEM: #27 PER PHY G793 ~~E27-01 WR~~ E27-01 WRA

# Certificate of Death

Reg. No. 2001 09223

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Margaret Green

2. Date of Death Month: March Day: 23 Year: 2001

3. Time of Death: 6:00p M

4a. Facility Name (If not institution, give street and number): union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

**Funeral Director**

5. Social Security Number: 216-34-3094

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 68 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 12-25-32

9. Birthplace (State or Foreign Country): SC

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 5473 Moores Run Drive

10f. Zip Code: 21206

10g. Citizen of What Country? USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - Americen Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 9th Grade

College (1-4or 5+): NA

16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Dietician worker

18b. Kind of Business/Industry: Baltimore city Sch

17. Father's Name (First, Middle, Last): Avens Greg

18. Mother's Name (First, Middle, Maiden Sumame): Rosie M. Briggs

19a. Informant's Name/Reletionship (Type, Print): Marilyn Shuler

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 2108 Lukewood Drive Baltimore, Maryland 21207

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Cem. Date: 03-30-01

20c. Location - City or Town, State: Timonium, MD

21. Signeture of Funeral Service Licensee: ▶ Gladys Warner

22. Name and Address of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. Pulmonary Embolism — Approximate Interval: 30 MINUTES

Due to (or es a consequence of):

b. orthopedic Surgery — Approximate Interval: 30 DAYS

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Obesity — Approximate Interval: 10 YEARS

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetel death 3☐Ectopic pregnency 4☐Pregnent et time of deeth 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23e. Did tobacco use contribule to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24e. Was an autopsy performed? 1☒Yes 2☐No

24b. Were eulopsy findings available prior to completion of cause of deeth? 1☐Yes 2☒No

**Medical Certification; To Be Completed by Physician/Medical Examiner**

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one)

Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Menner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide ~~5☐Pending investigation~~ 8☐Could not be determined

28a. Dete of Injury (Month, Day Yeer)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, dale and place, and due to the cause(s) and manner as steted. 2☐**Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, dete and piece, end due to the cause(s) and manner stated.

29b. Signeture and title of certifier: ▶ [illegible], MD

29c. License number: AT2138946

29d. Dale signed (Month, Day, Year): 3/23/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BRIAN EDWARD TIPPETT UNION MEMORIAL HOSPITAL BALTIMORE, MD

**State Registrar**

31. Date filed (Month, Day, Year): MAR 2 7 2001

32. Registrar's Signature: ▶ Sandra G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2001 09224

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Vernal Estelle Gordon
2. Date of Death Month Day Year: March 25, 2001
3. Time of Death: 2:40 AM
4a. Facility Name *(If not institution, give street and number)*: Hospice of Baltimore - Gilchrist Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 212-16-0458
6. Sex: 1☐ M 2☐ F XX
7. Age *(In yrs. last birthday)*: 81 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 09/17/1919
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Glen Arm
10d. Inside City Limits: 1☐ Yes 2☒ No XX
10e. Street and Number: 4319 Long Green Road
10f. Zip Code: 21057
10g. Citizen of What Country?: United States

11. Meritel Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Rece - American Indien, Black, White, etc. *Specify:* white

15. Decedent's Educetion *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / Collega (1-4or 5+): 4
16a. Decedent's Usuei Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Ross Gilbert Kirk
18. Mother's Neme *(First, Middle, Maiden Sumame)*: Agusta Stella Zimmerman

19e. Informent's Neme/Relationship *(Type, Print)*: Ruth Lawrence/daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1 Windmill Chase Sparks, Maryland 21152

20e. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removei from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, crematory or other piece)*: Wilson UM Cemetery
Dete: 03/28/2001
20c. Location - City or Town, State: Long Green, Maryland

21. Signature of Funeral Service Licensee: Stephen D. Coster M01122
22. Name end Address of Feciility: Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204

**Physician /Medical Examiner**

23a. Pert1. Enter the disease, or complicetions thet ceused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heert feiiure. List only one ceuse on eech line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in deeth)
a. end-stage obstructive Lung disease — month

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in deeth) Last
b.
Due to (or es a consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: recurrent pulmonary embolism

23b. Did tobacco use contributa to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☒ Other *(Specify)* Hospice

27. Menner of Death: 1☒ Natufai 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) end menner as stated. 2☐ **Medical Examiner:** On the besis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) end menner steted.

29b. Signeture end title of certifier: A. Anthony Riley, MD
29c. License number: D25205
29d. Date signed *(Month, Day, Year)*: March 25, 2001

30. Nama and address of person who completed ceuse of death (Item 23a) (Type, Print): W. A. Riley GBMC 6701 N. Charles St. Balto. MD 21204

**State Registrar**

31. Date filed *(Month, Dey, Year)*: MAR 27 2001
32. Registrar's Signeture: Jeanne G. Sparks

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Vernal Gordon March 25, 2000 0240A
Baltimore, Maryland 21215-0036

**Division of Vital Records, P.O. Box 68760,**

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

ADMEND ITEM: #26 PER PHY G793 3-27-01 WR.

# Certificate of Death

Reg. No. 2001 09225

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Marie Gapsis

2. Date of Death: Month March, Day 13, Year 2001

3. Time of Death: 3:24 P.M.

4a. Facility Name (If not institution, give street and number): North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 213 03 6263

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): May 23, 1920

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Linthicum

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6429 Oak Park Ct.

10f. Zip Code: 21090

10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4or 5+):

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Seamstress

16b. Kind of Business/Industry: Tailor Shop

17. Father's Name (First, Middle, Last): Dominic Barracato

18. Mother's Name (First, Middle, Maiden Surname): Frances (not available)

19a. Informant's Name/Relationship (Type, Print): Ronald Gapsis / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6429 Oak Park Ct. Linthicum, Maryland 21090

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Redeemer Cemetery

Date: 3/16/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Donna M Zramiewski

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Arrhythmia — 1 hour

Due to (or as a consequence of):

b. Coronary Artery Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

#26

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Pulmonary Disease

History of Breast Cancer

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA — Other: 4☐ Nursing Home 5☐ Residence ~~6☒ Other (Specify)~~ ~~Living~~ Assisted

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: 031557

29d. Date signed (Month, Day, Year): March 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ruel M. DeCruz 3001 S Hanover St Baltimore, Md. 21225

**State Registrar**

31. Date filed (Month, Day, Year): MAR 2 7 2001

32. Registrar's Signature: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 09226

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Douglas K. Gardner, Sr. | March 24, 2001 | 2:30p M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Brightwood Nursing Center | Baltimore | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-42-4989 | 1 XX M 2 ☐ F | 58 Yrs. | | | Nov. 16, 1942 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Baltimore | Baltimore | 1 ☐ Yes 2 XX No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 6090 Falls Rd. | 21209 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 XX If Yes, Give Year or Dates: | 1 ☐ Yes 2 XX No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 11th | | Truck Driver | Family Business |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Albert Gardner | Vera Gouker |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Douglas Gardner, Jr.(Son) | 10 Mulrany Ct. Timonium, MD 21093 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Balto-Wash Crematory | 3/27 | Laurel, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Michael Carpenter | Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Rd. Balto, MD 21211 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. End Stage Renal Disease | 6 months |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. Diabetes Mellitus | 20 years |
| | Due to (or as a consequence of): c. Peripheral Vascular disease | 20 years |
| | Due to (or as a consequence of): d. Coronary artery disease | 20 years |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown | 23d. Date of delivery Month Day Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1 XX Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown | 1 ☐ Yes 2 XX No | 1 ☐ Yes 2 ☐ No |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 ☐ Yes 2 XX No | Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 XX Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 XX Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ Yes 2 ☐ No | |
| | 26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one)
1 XX **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Tamara Sobel MD | D45432 | March 26, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
TAMARA SOBEL, MD 21 CROSSROADS DRIVE #400 OWINGS MILLS MD 21117

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 27 2001 | Rebecca G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09227

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Pedman Wilbourn golding

2. Date of Death: Month March Day 21 Year 2001

3. Time of Death: 0250 AM

4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: None

6. Sex: XX M 2 ☐ F

7. Age (In yrs. last birthday): 70 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 9, 1931

9. Birthplace (State or Foreign Country): Jamaica, W.I.

Usual Residence of Decedent

10a. State: West Indies

10b. County:

10c. City, Town or Location: Kingston, Jamaica

10d. Inside City Limits: 1 ☐ Yes 2 XX No

10e. Street and Number: First Spring District King Stone 9 Stone Hill P.O.

10f. Zip Code: Not Known

10g. Citizen of What Country? Jamaica, W.I.

11. Marital Status: 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XX No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes XX No Specify:

14. Race - American Indian, Bleck, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): College (1-4or 5+): 3 Years

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Entertainer/ Poetry Writer

16b. Kind of Business/Industry: Ras Records

17. Father's Name (First, Middle, Last): Arnold Golding

18. Mother's Neme (First, Middle, Meiden Surname): Christina Reynolds

19a. Informant's Name/Relationship (Type, Print): Millicent Golding/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 1962 University Ave #3N Bronx, New York 10453

20a. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removat from State 4 ☐ Donetion 5 ☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Golding Family Plot

Date: UNKNOWN

20c. Location - City or Town, State: Kingston, jamaica

21. Signeture of Funeral Service Licensee: ▶ Jerry Harris

22. Name end Address of Facility: Chatman-Harris Funeral Home 5240 Reisterstown Road Baltimore, Maryland21215

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediete Ceuse (Final disease or condition resulting in death)

a. Sepsis — 1 week

Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or es e consequence of):

c.

Due to (or as e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Clostridium difficile colitis

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 X No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No

26. Place of Death (Check only one): Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 X Neturat 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office buiiding, etc. (Specify)

28f. Location (Street and Number or Rurei Route Number, City or Town, Stete)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated. 2 ☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, dete and ptace, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: ▶ Brian L. McClune DO

29c. License number: RES 000

29d. Date signed (Month, Day, Year): March 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Brian L. McClune DO; Sinai Hospital of Baltimore

**State Registrar**

31. Date filed (Month, Day, Year): MAR 27 2001

32. Registrar's Signature: ▶ S Sparks

ORIGINAL

DHMH 16 Rev 6/95

---

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Known as Pedman Golding

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

2001 09228
Reg. No.

GRUNWALD Boleslaw
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): BOLESLAW A. GRUNWALD, JR.
2. Date of Death (Month, Day, Year): MARCH 22, 2001
3. Time of Death: 12:50 PM
4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: AA COUNTY

**Funeral Director**

5. Social Security Number: 217-24-1527
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 72 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUG. 28, 1928
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: GLEN BURNIE
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 302 WENDE WAY
10f. Zip Code: 21061
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No
If Yes, Give Year or Dates: unknown dates
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ELECTRICIAN
16b. Kind of Business/Industry: U.S. GOVERNMENT

17. Father's Name (First, Middle, Last): BOLESLAW GRUNWALD
18. Mother's Name (First, Middle, Maiden Surname): KARTZYNA WOLINSKI

19a. Informant's Name/Relationship (Type, Print): OLGA GRUNWALD (WIFE)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 302 WENDE WAY, GLEN BURNIE, MARYLAND 21061

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): HOLY ROSARY CEMETERY
Date: MARCH 26, 2001
20c. Location - City or Town, State: DUNDALK, MD.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ischemic bowel disease with intestinal gangrene

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of): b. end stage renal disease
Due to (or as a consequence of): c. coronary artery disease
Due to (or as a consequence of): d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D38547
29d. Date signed (Month, Day, Year): 3/23/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVE Y. CHOI M.D. 7845 OAKWOOD Rd # 205 GLEN BURNIE, MD 21061

**State Registrar**

31. Date filed (Month, Day, Year): MAR 27 2001
32. Registrar's Signature: [signature] Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

2001 09229 Reg. No.

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|
| PHYLLIS | GEISLER | MARCH 23, 2001 | 2:45 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 9048 BELLWART WAY | COLUMBIA | HOWARD |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 192-32-9661 | 1☐M 2☒F | 58 Yrs. | | | AUG 30 1942 | PA. |

**To Be Completed by Funeral Director**

Usuet Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | HOWARD | COLUMBIA | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 9048 BELLWART WAY | 21045 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Yeer or Dates: | 1☐Yes 2☒No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementery/Secondary (0-12) | College (1-4or 5+) | TEACHER | EDUCATION |
| | 4 | | |

| 17. Father's Neme (First, Middle, Last) | 18. Mother's Name (First, Middle, Meiden Sumame) |
|---|---|
| MORRIS MOSSOVITZ | IDA HURWITZ |

| 19e. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| MR. ALLAN GEISLER/HUSBAND | 9048 BELLWART WAY COLUMBIA, MD 21045 |

| 20a. Method of Disposition | 20b. Place of Disposition (Neme of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removel from State 4☐Donation 5☐Other (Specify) | ARLINGTON-CHIZUK AMONO CONGREGATION | 3/25/2001 | BALTIMORE, MD. |

21. Signature of Funerel Service Licensee ▶ Scott M. Cuttler

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the diseese, or complicetions that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. metastatic pancreatic cancer — Aug 1999

Due to (or as a consequence of):
b. renal failure — March 2001

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as e consequence of):
d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnency | 23d. Date of delivery Month Dey Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetel deeth 3☐Ectopic pregnancy 4☐Pregnant at time of deeth 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probebly 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings availeble prior to completion of cause of deeth? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☒No |

25. Wes case referred to medicel examiner? 1☐Yes 2☒No

28. Place of Death (Check only one)
Hospitel: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☒Residence 8☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and menner es steted. 2☐Medical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the causa(s) end manner steted.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Dana A. Jabour MD | D0053070 | March 23, 2001 |

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print)
Johns Hopkins Oncology Center 401 N. Broadway Balt, MD 21231

**State Registrar**

| 31. Date filed (Month, Dey, Year) | 32. Registrar's Signature |
|---|---|
| MAR 27 2001 | ▶ Geneva G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 09230

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Harriet Beth Granet

2. Date of Death — Month: MARCH Day: 21 Year: 2001

3. Time of Death: 8:45am

4a. Facility Name (If not institution, give street and number): 101 EAST HIGHFIELD RD.

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 214-46-2900

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 49 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 01/21/1952

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 101 EAST HIGHFIELD RD.

10f. Zip Code: 21218

10g. Citizen of What Country: USA

11. Meritel Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): — College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ATTORNEY

16b. Kind of Business/Industry: ATTORNEY

17. Father's Name (First, Middle, Last): MILTON GRANET

18. Mother's Name (First, Middle, Maiden Surname): GRETA HERSCH

19a. Informant's Name/Relationship (Type, Print): THOMAS PERKINS(HUSBAND)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 101 EAST HIGHFIELD RD. BALTO.,MD. 21218.

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removel from Stete 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): NEW CATHEDRAL CEM. Date: 03/23/2001

20c. Location - City or Town, State: BALTO.,MD.

21. Signeture of Funerel Service Licensee: ▶ William R. Jenkins III

22. Neme end Address of Facility: HENRY W. JENKINS & SONS CO. 6500 YORK RD. BALTO.,MD. 21212.

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on aech line.

Approximate Interval Between Onset and Death

Immediate Cause (Finat disease or condition resulting in death): a. metastatic esophageal cancer — 14 months

Due to (or as a consequence ot):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence ot):

c.

Due to (or as a consequenca of):

d.

Part II. **Other signifitcant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the causa of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy tindings available prior to completion ot cause of death? 1☐ Yes 2☐ No

25. Was casa referred to medical examiner? 1☐ Yes 2☒ No

26. Place ot Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time ot Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece ot Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Phystcian**: To the best ot my knowledge, death occurred at the time, date and piace, and due to the cause(s) and mannar as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, tn my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and title ot certifier: ▶ [signature]

29c. License number: D28239

29d. Date signed (Month, Day, Year): 3/22/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Nancy Davidson MD, 1650 Orleans St, Baltimore MD 21231-1000

**State Registrar**

31. Date filed (Month, Day, Year): MAR 27 2001

32. Registrer's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit case.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

8

12

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09231

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): JULIA - GRACE

2. Date of Death: Month 03 Day 19 Year 2001

3. Time of Death: 3.10 PM

4a. Facility Name (If not institution, give street and number): Mariner Health of North Arundel

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 213-16-6063

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 5/18/1919

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Glen Burnie

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 522 Kent Road

10f. Zip Code: 21060

10g. Citizen of What Country? U.S.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Charles Wheeler

18. Mother's Name (First, Middle, Maiden Surname): Ida Franklin

19a. Informant's Name/Relationship (Type, Print): Mary Wright / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 522 Kent Road Glen Burnie, Maryland 21060

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Meadowridge Mem. Park | Date: 3/22/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Donna M Zromiewski

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Arrythmia (Bradycardia) Minutes

Due to (or as a consequence of):

b. Amiodarone Toxicity

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic Renal Failure with Severe Anemia, Hypothyroidism, Vaginal Yeast Infection, Coronary Artery Disease, Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rita Khandelwal, M.D. Attending Physician

29c. License number: D 29873

29d. Date signed (Month, Day, Year): 03/20/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RITA KHANDELWAL, M.D. 1600 S. CRAIN HWY #201, GLEN BURNIE Md. 21061

**State Registrar**

31. Date filed (Month, Day, Year): MAR 26 2001

32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09232

Patient known as Ronald Hyde

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): RONALD W. HYDE
2. Date of Death: Month March Day 18 Year 2001
3. Time of Death: 11:10 pm
4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 215-42-2277
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 55 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 07-01-1945
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: GWYNN OAK
10d. Inside City Limits: 1 ☐ Yes 2 ☑ No
10e. Street and Number: 3413 RETLAW ROAD
10f. Zip Code: 21207
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH GRADE; College (1-4or 5+): 2 YRS
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): POLICE OFFICER
16b. Kind of Business/Industry: BALTIMORE CITY

17. Father's Name (First, Middle, Last): ARTHUR HYDE, SR.
18. Mother's Name (First, Middle, Maiden Surname): HELEN CAREY

19a. Informant's Name/Relationship (Type, Print): BRENDA HYDE / WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3413 RETLAW RD., BALTO. MD. 21207

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): WOODLAWN CEMETERY
Date: 03.23.01
20c. Location - City or Town, State: BALTO. MD

21. Signature of Funeral Service Licensee: ▶ Vaughn C [illegible]
22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL' PIKE, BALTO. MD. 21207

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Pneumonia | 1 month |
| Due to (or as a consequence of): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — b. | Pneumocystis Carinii infection | 1 month |
| Due to (or as a consequence of): | | |
| c. | Chronic lymphocytic leukemia | 6 months |
| Due to (or as a consequence of): | | |
| d. | Small cell lymphoma | 6 months |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Pneumothorax

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Rajiv R Doshi MD
29c. License number: RES 000
29d. Date signed (Month, Day, Year): March 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Rajiv R Doshi MD Sinai Hospital of Baltimore 2401 West Belvedere Avenue

**State Registrar**

31. Date filed (Month, Day, Year): MAR 27 2001
32. Registrar's Signature: [illegible]

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

DHMH 16 Rev 6/95

RKD

01-1566-510

DINO HESTER

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar ADMEND ITEMS: #23 PART I, 27, 28A-E PER MEO G794 4-5-01 WR *Certificate of Death* Reg. No. 2001 09233

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| DINO KIM HESTER | MARCH 20, 2001 | 4:17P. M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| SINAI HOSPITAL | BALTIMORE | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 205-44-1217 | 1☑M 2☐F | 46 Yrs. | | | 05-02-1954 | MD |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | N/A | BALTIMORE | 1☑Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3018 WYLIE AVENUE | 21215 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☑Married 3☐Widowed 4☐Divorced | 1☐Yes 2☑No If Yes, Give Year or Dates: | 1☐Yes 2☑No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12TH GRADE | N/A | LABORER | CAR WASH |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| JOHN HESTER | DOLORES STALLING |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| ANDREA ALLEN / SISTER | 6253 ALLISON CT., MASON, OH 45040 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☑Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | METRO CREMATORY | 03-23-01 | BALTO. MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Daughn C H | CREMATION SERVICES 5151 BALTO. NATL PIKE, BALTO. MD. 21229 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): NARCOTIC AND ALCOHOL INTOXICATION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. _____ Due to (or as a consequence of):

b. _____ Due to (or as a consequence of):

c. _____ Due to (or as a consequence of):

d. _____

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | Month / Day / Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24e. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☒Yes 2☐No | 1☒Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☒Yes 2☐No | Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☒Could not be determined | FOUND: 3-20-01 | UNKNOWN M | 1☐Yes 2☒No | SUBJECT INGESTED DRUGS AND ALCOHOL |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| FOUND AT RESIDENCE | 3818 WYLIE AVE. BALTIMORE, MARYLAND |

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner as stated.
2☒ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ J M. Tit | O.C.M.E. | MARCH 21, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JACK M. TITUS, M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 27 2001 | ▶ Renee G Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed, filed in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 09234

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Howard Hammonds

2. Date of Death Month: March Day: 24 Year: 2001

3. Time of Death: 3:55 PM

4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview medical Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore City

**Funeral Director**

5. Social Security Number: 219-32-0604

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 64 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 28, 1936

9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Dundalk

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 6716 Brentwood Avenue

10f. Zip Code: 21222

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1956-58

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 Years; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Maintenance Mechanic

16b. Kind of Business/Industry: Automobile Service

17. Father's Name (First, Middle, Last): Monroe Hammonds

18. Mother's Name (First, Middle, Maiden Surname): Viola Schrader

19a. Informant's Name/Relationship (Type, Print): Mrs. Frieda Hammonds (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6716 Brentwood Ave. Dundalk, Maryland 21222

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Christ Lutheran Cem.

Date: 3/28/2001

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Gregory E. Ruck

22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis — 2 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. hepatocellular Carcinoma — 1 month

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rebecca Gottesman MD, Resident Physician

29c. License number: 21015

29d. Date signed (Month, Day, Year): March 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Rebecca Gottesman, 4940 Eastern Avenue, Baltimore, Maryland 21224

**State Registrar**

31. Date filed (Month, Day, Year): MAR 27 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit case.

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09235

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): MONROE HUGHES

2. Date of Death: Month March, Day 16, Year 2001

3. Time of Death: 4:40 am

4a. Facility Name (If not institution, give street and number): VA Medical Center, Fort Howard MD 21052

4b. City, Town, or Location of Death: Fort Howard

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 251-50-8328

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 64 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): 07-24-1936

9. Birthplace (State or Foreign Country): South Carolina

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 2819 WOODLAND AVENUE

10f. Zip Code: 21215

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH GRADE; College (1-4or 5+): 2 YRS

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LIMOUSINE DRIVER

16b. Kind of Business/Industry: TRANSPORTATION

17. Father's Name (First, Middle, Last): THOMAS HUGHES

18. Mother's Name (First, Middle, Maiden Surname): SALLIE SIMUEL

19a. Informant's Name/Relationship (Type, Print): REGINALD SMITH / NEPHEW

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8556 CARBINE PLACE, GALLOWAY OHIO 43119

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): GARRISON FOREST

Date: 03-22-01

20c. Location - City or Town, State: OWINGS MILLS, MD

21. Signature of Funeral Service Licensee: Vaughn C

22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL SERVICE, 5151 BALTO. NATL. PIKE, BALTO. MD. 21229

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Lung Cancer — 5 Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Marcos B. Galicia MD

29c. License number: D0015698

29d. Date signed (Month, Day, Year): March 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Marcos B. Galicia, MD 9600 North Point Road, Fort Howard, MD 21052

**State Registrar**

31. Date filed (Month, Day, Year): MAR 2 7 2001

32. Registrar's Signature:

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Hughes, Monroe

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09236

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Carol C. Holloman
2. Date of Death: Month MARCH Day 24, Year 2001
3. Time of Death: 6:15 AM
4a. Facility Name (If not institution, give street and number): Joseph Richie Hospice
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 579-98-3302
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 34 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 9, 1967
9. Birthplace (State or Foreign Country): N. Carolina

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 21 N. Ellamont St.
10f. Zip Code: 21229
10g. Citizen of What Country? USA

11. Marital Status: 1☑ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Private Duty Nurse
16b. Kind of Business/Industry: Nursing

17. Father's Name (First, Middle, Last): John Holloman
18. Mother's Name (First, Middle, Meiden Surname): Carolyn Hughes

19a. Informent's Neme/Relationship (Type, Print): Theresa Spain - aunt
19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 609 Allendale Balto., MD. 21229

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from Slete 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other place): Mt. Zion Cemetery
Date: 3-28-01
20c. Location - City or Town, State: Lansdowne, MD.

21. Signature of Funerel Service Licensee: Carol F. March
22. Name and Address of Facility: Gary P. March Funeral Home P.A. 2410 Fredhilton Pass Balto., MD 21229

**Physician /Medical Examiner**

23a. Part I. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line.

Approximate Interval Between Onset and Deeth

Immediate Cause (Final disease or condition resulting in death): a. AIDS — Due to (or as a consequence of): — 9 yrs

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last:
b. — Due to (or as e consequence of):
c. — Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Piece of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☑ Other (Specify) Hospice

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of *my* knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as stated. 2☐ **Medical Examiner**: On the besis of examinetion and/or investigation, in *my* opinion, deeth occurred at the time, date and place, end due to the ceuse(s) and manner steted.

29b. Signature and title of certifier: John W. Payne, MD
29c. License number: D13012
29d. Date signed (Month, Day, Year): March 26, 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John Payne 4565 N. Charles St 21204

**State Registrar**

31. Date filed (Month, Day, Year): MAR 2 7 2001
32. Registrar's Signature: Pamela G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

5

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

ADMEND ITEM: #27 PER MEO G793 3-27-01 WR. *Certificate of Death* Reg. No. 2001 09237

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Paul Thomas Healy

2. Date of Death Month Day Year: March 4, 2001

3. Time of Death: 7:14 a.m.

4a. Facility Name *(If not institution, give street and number)*: Memorial Hospital & Medical Center

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

**Funeral Director**

5. Social Security Number: 233-34-6023

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec. 10, 1925

9. Birthplace *(State or Foreign Country)*: WV

Usual Residence of Decedent

10a. State: WV

10b. County: Mineral

10c. City, Town or Location: Keyser

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 111 Maple Avenue

10f. Zip Code: 26726

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): | College (1-4or 5+): 8+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Physician

16b. Kind of Business/Industry: Medical

17. Father's Name *(First, Middle, Last)*: Frank A. Healy

18. Mother's Name *(First, Middle, Maiden Surname)*: Ellen Laffey

19a. Informant's Name/Relationship *(Type, Print)*: Wendy Healy -- Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 111 Maple Avenue; Keyser, WV 26726

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Scarpelli Funeral Home | Date: 03/06 2001

20c. Location - City or Town, State: Cresaptown, MD

21. Signature of Funeral Service Licensee: ▶ Harold Dean Nofsinger

22. Name and Address of Facility: Markwood Funeral Home 111 S. Mineral Street; Keyser, WV 26726

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction — 1/2 hour

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypertension and Diabetes — Years

Due to (or as a consequence of):

c. Fracture Right Hip — 3 Days

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No released

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*: 03/01/2001

28b. Time of Injury: 8:10 a M

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: Patient fell at home

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: Home

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 111 Maple Ave; Keyser, WV

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: D0017862

29d. Date signed *(Month, Day, Year)*: March 6, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Samuel Harshberger, M.D.; 925 Seton Drive; Cumberland, MD 21502

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 0 6 2001

32. Registrar's Signature: ▶ [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 09238

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Margaret L. Himmer

2. Date of Death (Month, Day, Year): March 24, 2001

3. Time of Death: 1:40 AM

4a. Facility Name (If not institution, give street and number): Gilchrist Home for Hospice

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore Co.

**Funeral Director**

5. Social Security Number: 213-03-7512

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 31, 1916

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Cockeysville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 10320 Malcolm Circle

10f. Zip Code: 21030

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Administrative Assistant

18b. Kind of Business/Industry: Johns Hopkins

17. Father's Name (First, Middle, Last): Leland Newnam

18. Mother's Name (First, Middle, Maiden Surname): Edna Redding

19a. Informant's Name/Relationship (Type, Print): Edna Davies Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11 Scottsdale Ct. Lutherville, MD 21093

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens of Faith

Date: 3/27/01

20c. Location - City or Town, State: Fullerton, Maryland

21. Signature of Funeral Service Licensee: Tracy Hess Caputo

22. Name and Address of Facility: Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, MD 21211

**Physician /Medical Examiner**

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Non-small cell Lung Cancer — 1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnent at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive Pulmonary Disease

23e. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

28. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 8☑ Other (Specify) HOSPICE

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: William D. McConnell MD

29c. License number: D42129

29d. Date signed (Month, Day, Year): 3-24-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William D. McConnell MD 500 W. University Baltimore 21210

**State Registrar**

31. Date filed (Month, Day, Year): MAR 27 2001

32. Registrar's Signature: Jeanne G Sparks

**To Be Completed by Funeral Director**

Baltimore, Maryland 212154036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Margaret Himmer March 24, 2001 @ 1:40am

DHMH 17 Rev 1/2001

ORIGINAL

CPS
01-1527-025
WILLIAM HOCKENBERRY

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09239

For State Registrar AMEND ITEM 24a & b,25,26 per DVR G794 041301 SS
AMEND ITEM 23a,ptII,27,28a-f per ME G794 040901 SS

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): William E. Hockenberry
2. Date of Death: Month March, Day 18, Year 2001
3. Time of Death: 15:20 PM
4a. Facility Name (If not institution, give street and number): 412 St. John St.
4b. City, Town, or Location of Death: Havre De Grace
4c. County of Death: Harford

**Funeral Director**

5. Social Security Number: 215-42-5752
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 57 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec 22, 1943
9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: MD
10b. County: Harford
10c. City, Town or Location: Havre de Grace
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 412 St. John Street
10f. Zip Code: 21078
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 61-64
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Dispatcher
16b. Kind of Business/Industry: Transportation

17. Father's Name (First, Middle, Last): Herman Hockenberry
18. Mother's Name (First, Middle, Maiden Surname): Edna McGonigal

19a. Informant's Name/Relationship (Type, Print): Mel Hagan /Friend
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 912 N. Stepney Street, Aberdeen, MD 21001

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MD Veterans Cemetery
Date: Mar 27 @ 2001
20c. Location - City or Town, State: Owings Mill, MD

21. Signature of Funeral Service Licensee: Laura C. Hardesty
22. Name and Address of Facility: Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, MD

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. MIXED DRUG INTOXICATION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [X] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [X] Other (Specify) SCENE

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year): found 3-18-01
28b. Time of Injury: found 1:22 PM
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: subject took drugs
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): found at home
28f. Location (Street and Number or Rural Route Number, City or Town, State): 412 St. John St., Havre De Grace, MD

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dennis J. Chuteno
29c. License number: OCME
29d. Date signed (Month, Day, Year): March 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis Chuteno 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): MAR 27 2001
32. Registrar's Signature: Donna B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification; To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM 26 per phys G793 032701 SS

# Certificate of Death

Reg. No. 2001 09240

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Ida J. Harpe

2. Date of Death Month Day Year: March 24, 2001

3. Time of Death: 8:45 PM

4a. Facility Name *(If not institution, give street and number)*: 209 North Woodlawn Avenue

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 220-05-3790

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JUNE 25, 1917

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 209 North Woodlawn Avenue

10f. Zip Code: 21401

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Rece - American Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: UNK. Owings

18. Mother's Name *(First, Middle, Meiden Surneme)*: UNK.

19a. Informant's Neme/Relationship *(Type, Print)*: Henry R. Harpe/Husband

19b. Melling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 209 N. Woodlawn Avenue Annapolis, MD 21401

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel from State 4☐ Donation 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Metro Crematory Inc.

Dete: 3-26-01

20c. Location - City or Town, Stete: Baltimore, MD

21. Signature of Funeral Service Licensee: Thomas Gregor

22. Name end Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complicetions that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel diseese or condition resulting in deeth): e. Parkinsons Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Last

b.

Due to (or es a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ASCAD

CVA

SSS - S/P pacemaker

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medicat examiner? 1☐ Yes 2☑ No

26. Piece of Death *(Check only one)*: Hospital: 1☐ Inpatient ~~2☐ ER/Outpatient~~ 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rurel Route Number, City or Town, Stete)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, dete and piece, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the besis of exemination and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robt M

29c. License number: D 26873

29d. Dete signed *(Month, Day, Year)*: 3/28/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 137 old Solomons Isl Rd Annapolis, Md 21401

**State Registrar**

31. Dete filed *(Month, Day, Year)*: MAR 2 7 2001

32. Registrar's Signature: Denise D Sparks

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit copy.

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No: 2001 09241

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|
| BETTY | HEATH | MARCH 24, 2001 | 09:08 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| CHESAPEAKE HOSPICE HOUSE | LINTHICUM | ANNE ARUNDEL |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-24-1180 | 1☐M 2☒F | 78 Yrs. | | | MARCH 5, 1923 | MARYLAND |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | ANNE ARUNDEL | GLEN BURNIE | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 603 MARLBORO ROAD | 21061 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 9 | N/A | DAYCARE | NURSERY |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| EDWARD VANPELT | BESSIE BASSFORD |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| MR. JAMES G. HEATH (HUSBAND) | 603 MARLBORO ROAD, GLEN BURNIE, MD 21061 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | MARYLAND VETERANS CEMETERY | 03/27/2001 | CROWNSVILLE MARYLAND |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ R. George Hyde | SINGLETON FUNERAL HOME, P.A. 1 SECOND AVE. S.W., GLEN BURNIE, MD 21061 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Breast Cancer — 1 YR.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. Breast Cancer — 5 1/3 YRS.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☒No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) Chesapeake Hospice House |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☒**Certifying Physician**: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner es stated. 2☐**Medical Examiner**: On the besis of exemination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to tha cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ | 031551 | March 26, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUITE 602
DR. RUSSELL DeLUCA 1600 CRAIN HIGHWAY, S., GLEN BURNIE, MARYLAND 21061

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 2 7 2001 | ▶ Barbara G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

2001 09242 Reg. No.

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| ARTHUR DAVID HOWARD | March 20, 2001 | 7:55P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 102 Yorkleigh Road | Towson | Baltimore County |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-16-8568 | 1☒M 2☐F | 77 Yrs. | | | March 20, 1924 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore County | Towson | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 102 Yorkleigh Road | 21204 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: WW2 | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondery (0-12) | College (1-4or 5+) | | |
| 8th | | Machinist | Koppers Company |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Neme (First, Middle, Meiden Surneme) |
|---|---|
| Elmer Lewis Howard, Sr. | Ada Beulah Coombs |

| 19a. Informant's Neme/Reletionship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Peggy L. Howard (Daughter) | 102 Yorkleigh Road, Towson, Maryland 21204 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, cremetory or other piece) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Dulaney Mem Grdns | 3/24/2001 | Timonium, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Martin D. Lawson | Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road, Baltimore, Maryland 21212 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errast, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Finet disease or condition resulting in deeth) | a. MYOCARDIAL infarction | |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last | b. | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

IF FEMALE:

| 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnent at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probebly 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☒No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Dete of Injury (Month, Dey Year) | 28b. Time of Injury M | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Netural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, In my opinion, deeth occurred at the time, date and place, and due to the causa(s) and manner stated.

| 29b. Signature end title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Robert Stoltz, MD | D30910 | 3/22/01 |

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)

ROBERT STOLTZ, M.D., 1447 York Road, Lutherville, Maryland 21093

**State Registrar**

| 31. Date filed (Month, Dey, Yeer) | 32. Registrar's Signature |
|---|---|
| MAR 27 2001 | Brenda G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09243

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): RAYMOND C. HOMMERBOCKER
2. Date of Death: Month MARCH Day 21 Year 2001
3. Time of Death: 0100 HRS
4e. Facility Name (If not institution, give street and number): ST AGNES HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 212-09-8636
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 29 1914
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore Co.
10c. City, Town or Location: Lansdowne
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 2205 Alletta Ave.
10f. Zip Code: 21227
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Machine Operator
16b. Kind of Business/Industry: American Can Co.
17. Father's Name (First, Middle, Last): Charles Hommerbocker
18. Mother's Name (First, Middle, Maiden Surname): Annie C. Kestler
19a. Informent's Name/Relationship (Type, Print): Rose A. Hommerbocker (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2205 Alletta Ave. Lansdowne, Md. 21227
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Memorial Park
Date: 3/26/2001
20c. Location - City or Town, State: Elkridge, Md.
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: McCully-Polyniak Funeral Home P.A. 237 E. Patapsco Ave. Baltimore, Md. 21225

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. ACUTE PULMONARY EDEMA — YEARS
Due to (or as a consequence of):
b. CARDIOMYOPATHY — YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
ACUTE RENAL FAILURE
CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No
25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] M.D.
29c. License number: P13601
29d. Date signed (Month, Day, Year): MARCH 21 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): NANA CEASAR STAGNES HOSPITAL 900 CATON AVENUE BALTIMORE MD 21229

**State Registrar**

31. Date filed (Month, Day, Year): MAR 27 2001
32. Registrar's Signature: [signature] B. Sparks

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME RAYMOND C. HOMMERBOCKER

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 09244

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Osyp George Horobijowskyj | MAR 22, 2001 | 5:55 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 3049 HICKORYMEDE DRIVE | ELLICOTT CITY | HOWARD |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212 42 2601 | 1 [X] M 2 [ ] F | 93 Yrs. | | | APRIL 1, 1907 | UKRAINE |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | HOWARD | ELLICOTT CITY | 1 [ ] Yes 2 [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3049 HICKORYMEDE DRIVE | 21042 | UKRAINE |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: | 1 [ ] Yes 2 [X] No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 4 | CIVAL ENGINEER | ENGINEERING |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| DAMIAN HORODIJOWSKYJ | MARCELLA N/A |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21042 |
|---|---|
| JOHN KORZ/SON-IN-LAW | 3049 HICKORYMEDE DRIVE ELLICOTTCITY MD |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | ST. MICHAEL CEMETERY | MARCH 24 2001 | BALTIMORE |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Catherine M. Zeiler | LILLY + ZEILER, INC. 1901 EASTERN AVE, BALTIMORE, MD. 21231 |

**Physician /Medical Examiner**

23a. Part I. Enter the diseasa, or complications that caused the daath. Do not entar the moda of dying, such as cerdiac or raspiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Batween Onsat and Death

| | | |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Congestive Heart Failure | 2 mos |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last | Due to (or es a consequence of): b. Coronery Artery Disease | 20 yrs |
| | Due to (or as a consequance of): c. | |
| | Due to (or as e consequence of): d. | |

| tF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnency | 23d. Date of delivary Month / Day / Year |
|---|---|---|
| 1 [ ] Yas 2 [ ] No 9 [ ] Unknown | 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnency 4 [ ] Pregnant at tima of death 5 [ ] Othar (specify) 9 [ ] Unknown | |

Part II. **Other significant conditions** contributing to deeth but not resulting in tha undarlying cause givan in Part I.

Aspiration Pneumonia

23e. Did tobacco use contribute to the causa of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

| 24a. Was an autopsy performed? | 24b. Ware autopsy findings available prior to completion of ceuse of death? |
|---|---|
| 1 [ ] Yes 2 [X] No | 1 [ ] Yas 2 [ ] No |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

| 25. Wes casa refarred to medical examiner? | 28. Place of Death (Check only one) | |
|---|---|---|
| 1 [ ] Yes 2 [X] No | Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Yaar) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] Yes 2 [ ] No | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and dua to the causa(s) and manner as stated.
2 [ ] **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, death occurred at tha lime, date and piece, and due to tha cause(s) and manner statad.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Yaar) |
|---|---|---|
| Warren M. Ross MD | D 17821 | march 23, 2001 |

30. Nama and address of person who complated cause of deeth (Item 23a) (Type, Print)
WARREN M. ROSS, M.D. 4801 Dorsey Hall Drive, Ellicott City MD 21042

**State Registrar**

| 31. Data filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 27 2001 | Jennie G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 09245

Mark Humphries Jr.

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Mack H. Humphries

2. Date of Death — Month: March; Day: 21; Year: 2001

3. Time of Death: 1:40 AM

4a. Facility Name *(If not institution, give street and number)*: North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Ann Arundel

**Funeral Director**

5. Social Security Number: 212 48 3659

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 52 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 26, 1948

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Pasadena

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 8685 Ft. Smallwood Road

10f. Zip Code: 21122

10g. Citizen of What Country?: U.S.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: Viet Nam

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Salesman

16b. Kind of Business/Industry: Beer Distributor

17. Father's Name *(First, Middle, Last)*: Mack H. Humphries Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary LaVerne Newgirg

19a. Informant's Name/Relationship *(Type, Print)*: Mary Lou Humphries / Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8685 Ft. Smallwood Road Pasadena, Maryland 21122

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MD State Veteran Cem.

Date: 3/23/01

20c. Location - City or Town, State: Crownsville, Maryland

21. Signature of Funeral Service Licensee: Donna M Zremiewski

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. (List only one cause on each line.)

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Advanced pharyngeal cancer — 1 1/2 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

alcoholic cardiomyopathy

Emphysema

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Hwan Soo Yoo, MD

29c. License number: D0053514

29d. Date signed *(Month, Day, Year)*: March 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Hwan Y. Yoo, MD. North Arundel Hospital

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 26 2001

32. Registrar's Signature: James D. Sparks

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

01-1647-510
MAIME E. JONES
ASP

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM 5 per fh G793 033001 SS **Certificate of Death**

Reg. No. 2001 09246

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Mamie E. Jones
2. Date of Death Month/Day/Year: MARCH 24 2001
3. Time of Death: 0918 M
4a. Facility Name (If not institution, give street and number): 2725 RIGGS AVE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: NA

**Funeral Director**

5. Social Security Number: ~~219-01-7733~~ 219-01-7773
6. Sex: 1☐M 2☐F XX
7. Age (In yrs. last birthday): 87 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 05-26-13
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐Yes 2☐No XX
10e. Street and Number: 2725 Riggs Avenue
10f. Zip Coda: 21216
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced X
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☐No XX If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No X Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th Grade
College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Custodian
18b. Kind of Business/Industry: Univ. of Maryland

17. Father's Name (First, Middle, Last): Clarence Johnson
18. Mother's Name (First, Middle, Maiden Surname): Mary Queen

19a. Informant's Name/Relationship (Type, Print): Charlotte H. Brown
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 443 Vermont Street Brooklyn, N.Y. 11207

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State XX 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory
Date: 03-27-2001
20c. Location - City or Town, State: Catonsville, MD

21. Signature of Funeral Service Licensee: Joseph R. Walter Jr
22. Name and Address of Facility: Baltimore, Maryland 21202
WM.C.March FH 1101 E. North Avenue

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Hypertensive Arteriosclerotic Cardiovascular Disease
Due to (or as a consequence of): b.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of): c.
Due to (or as a consequence of): d.

Approximate Interval Between Onset and Death

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown X
24a. Was an autopsy performed? 1☐Yes 2☒No X
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes X 2☐No
28. Place of Death (Check only one) Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) X SCENE
27. Manner of Death: 1☒Natural X 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. X

29b. Signature and title of certifier: [signature]
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): MARCH 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. LAWRENCE LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): MAR 2 7 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification; To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 09247

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Robert S.T. Johnson

2. Date of Death: Month 03, Day 20, Year 2001

3. Time of Death: 3:56 AM

4a. Facility Name (If not institution, give street and number): University of Maryland Medical System

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore City

**Funeral Director**

5. Social Security Number: 501-56-2278

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 53 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JUNE 5, 1947

9. Birthplace (State or Foreign Country): ND

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: SEVERN

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 7868 MANET WAY

10f. Zip Code: 21144

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LAWYER

16b. Kind of Business/Industry: REAL ESTATE

17. Father's Name (First, Middle, Last): ROGNVALDUR S. JOHNSON

18. Mother's Name (First, Middle, Maiden Surname): NETTIE OLSON

19a. Informant's Name/Relationship (Type, Print): PHYLLIS E. JOHNSON (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7868 MANET WAY, SEVERN, MARYLAND 21144

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MOUNTAIN CEMETERY

Date: 3/24/2001

20c. Location - City or Town, State: MOUNTAIN, ND

21. Signature of Funeral Service Licensee: [signature] M00395

22. Name and Address of Facility: SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Septic Shock

Due to (or as a consequence of):
b. Multi System Organ Failure — 6 WEEKS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown

23d. Date of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [✓] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one)
Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: [signature]

29c. License number: 08614

29d. Date signed (Month, Day, Year): 03/20/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MITCHELL A. CAHAN, MD DEPARTMENT OF SURGERY, UMMS. 22 S. GREENE ST, BALTIMORE, MD 21201

**State Registrar**

31. Date filed (Month, Day, Year): MAR 27 2001

32. Registrar's Signature: [signature] B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Amended Item#8 perFHG794 4/9/01 EW

## Certificate of Death

Reg. No. 2001 09248

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): MELVIN JONES SR.

2. Date of Death: Month MARCH Day 21 Year 2001

3. Time of Death: 2:18 am

4a. Facility Name (If not institution, give street and number): MARYLAND GENERAL HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE CITY

4c. County of Death:

**Funeral Director**

5. Social Security Number: 219-34-4868

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 62 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): ~~SEPT13, 1938~~ 9-18-38

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County:

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 123 N. WARWICK AVE.

10f. Zip Code: 21223

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ENTREPRENEUR

16b. Kind of Business/Industry: FURNITURE RESTORER

17. Father's Name (First, Middle, Last): JOHN COLEMAN

18. Mother's Name (First, Middle, Maiden Surname): FLORENCE JONES

19a. Informant's Name/Relationship (Type, Print): MELVIN JONES JR. SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4412 NORFOLK AVE. BALTO. MD 21216

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): METRO CREMATORY

Date: 3/24/2001

20c. Location - City or Town, State: CATONSVILLE MD

21. Signature of Funeral Service Licensee: ▶ E.N. WALKER JR

22. Name and Address of Facility: ESTEP BROS. FUNERAL SERVICE P.A. 1300 EUTAW PLACE BALTO. MD 21217

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE

Due to (or as a consequence of):

b. REFRACTORY HYPOTENSION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. HYPERTENSION

Due to (or as a consequence of):

d. DIABETES

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one)

Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(Jones, Melvin M621448)

29a. Certifier (Check only one): 1 [✓] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ (Alan Rhoades) MD

29c. License number: P14584

29d. Date signed (Month, Day, Year): 3/21/01 2:35 pm

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ALAN RHOADES, MD. C/O MARYLAND GENERAL HOSPITAL

**State Registrar**

31. Date filed (Month, Day, Year): MAR 2 7 2001

32. Registrar's Signature: ▶ Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

2001 09249
Reg. No.

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| MANUEL | | JARAMILLO | March 21 2001 | 1531 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| The Johns Hopkins Hospital | Baltimore City | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-34-6673 | 1☒M 2☐F | 81 Yrs. | | | 01/15/1920 | ECUADOR |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | N/A | BALTIMORE | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2925 N. CHARLES ST. | 21218 | ECUADOR |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: ECUADORIAN | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementery/Secondery (0-12) | College (1-4or 5+) | | |
| | 4YRS | CONSULATE TO ECUADOR | CONSULATE |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Sumame) |
|---|---|
| LIZARDO JARAMILLO | ROSA VASQUEZ |

| 19a. Informant's Neme/Retetionship (Type, Print) | 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) |
|---|---|
| CARMEN HOWARD(DAUGHTER) | 312 MERRIE HUNT DR. TIMONIUM,MD. 21093. |

| 20a. Method of Disposition | 20b. Piece of Disposition (Neme of cemetery, cremetory or other place) | Dete | 20c. Location - City or Town, Stete |
|---|---|---|---|
| 1☐Burial 2☒Cremetion 3☐Removal from Stete 4☐Donation 5☐Other (Specify) | GREEN MOUNT CREMATORY | 03/23/2001 | BALTO.,MD. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ William Sauers III | HENRY W. JENKINS & SONS CO. 6500 YORK RD. BALTO.,MD. 21212. |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complicetions thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediete Ceuse (Final diseese or condition resulting in death)

a. SEPSIS — Due to (or es a consequence of): — 24 HOURS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. PNEUMONIA — Due to (or as e consequenca of): — 12 DAYS

c. — Due to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnent in the past 12 months? 1☐Yes 2☐No 9☐Unknown | 23c. If yes, outcome of pregnency 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnent at time of death 5☐Other (specify) 9☐Unknown | 23d. Date of delivery Month / Dey / Year |
|---|---|---|

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SQUAMOUS CELL CANCER OF THE TONSIL

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☐No 3☑Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were eutopsy findings available prior to completion of cause of deeth? |
|---|---|
| 1☑Yes 2☐No | 1☐Yes 2☑No |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

| 25. Wes case relerred to medicat examiner? | 28. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☑No | Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA | Othar: 4☐Nursing Home 5☐Residenca 6☐Other (Specify) |

| 27. Menner of Death | 28e. Dete of Injury (Month, Day Yeer) | 28b. Time of Injury | 28c. Injury et Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑Netural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) | 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) |
|---|---|
| | |

29e. Certifier (Check only one)
1☑ **Certifying Phyaician:** To the best of my knowledge, death occurred at the time, date end placa, end due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated.

| 29b. Signeture and title of certifier | 29c. Licanse number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ J Brodie, MD | RES-000 | MARCH 21, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DANIEL BRODIE, 600 NORTH WOLF STREET, BALTIMORE, MD 21287

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 27 2001 | Penny B Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

8
10

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 09250

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: EARL JOHNSON JR.
2. Date of Death — Month: MARCH Day: 23 Year: 2001
3. Time of Death: 9:40 PM
4a. Facility Name *(If not institution, give street and number)*: HARBOR HOSPITAL CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 218-12-8291
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 76 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jan. 14, 1925
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6 Nann Avenue
10f. Zip Code: 21225
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Electrician
16b. Kind of Business/Industry: Ship Yard

17. Father's Name *(First, Middle, Last)*: Earl Leech Johnson, Sr.
18. Mother's Name *(First, Middle, Maiden Surname)*: Angeline Blahut

19a. Informant's Name/Relationship *(Type, Print)*: Cheryl Johnson (Daughter)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1614 Parkman Avenue Baltimore, MD 21230

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Bayview Crematory
Date: 3/29/01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Sharron Liggett
22. Name and Address of Facility: Gonce Funeral Home, P.A. 4001 Ritchie Highway Baltimore, MD 21225

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. SEPSIS — 48 HOURS

Due to (or as a consequence of):
b. URINARY TRACT INFECTION — 1 WEEK

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: HYPERTENSION, DIABETES, LIVER CIRRHOSIS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Guillermo Giangreco
29c. License number: R85001
29d. Date signed *(Month, Day, Year)*: MARCH 23 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GUILLERMO JOSE GIANGRECO HARBOR HOSPITAL CENTER

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 26 2001
32. Registrar's Signature: Geneva G. Sparks

ORIGINAL

DHMH 16 Rev 6/95

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit case.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09251

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): LINDORA KELLY
2. Date of Death Month Day Year: 03-22-2001
3. Time of Death: 5:05 PM
4a. Facility Name (If not institution, give street and number): ROCK GLEN NURSING HOME
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 068-28-9642
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 63 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 01-08-1938
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 3703 HARLEM AVENUE
10f. Zip Code: 21229
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 TH GRADE; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DIETICIAN
16b. Kind of Business/Industry: HEALTH CARE

17. Father's Name (First, Middle, Last): GEORGE SAVOY
18. Mother's Name (First, Middle, Maiden Surname): SANDRA QUEEN

19a. Informant's Name/Relationship (Type, Print): LEWIS KELLY / HUSBAND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3703 HARLEM AVE., BALTO. MD. 21229

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): KING MEMORIAL PARK
Date: 3-28-01
20c. Location - City or Town, State: RANDALLSTOWN, MD

21. Signature of Funeral Service Licensee: ▶ Vaughn C
22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL. PIKE, BALTO. MD. 21229

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. End Stage Renal Disease — many

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: S/P CVA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Attending MD
29c. License number: D 36942
29d. Date signed (Month, Day, Year): March 27, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): B. TURAKHIA, MD 1009, Fredrick Rd. Baltimore, MD 21228

**State Registrar**

31. Date filed (Month, Day, Year): MAR 2 7 2001
32. Registrar's Signature: ▶ Sandra G Sparks

ORIGINAL

DHMH 16 Rev 6/95

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar ADMEND ITEM: # 8 PER F.H. G793 3-27-01 WR **Certificate of Death**

Reg. No. 2001 09252

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| O'NEAL W. KOGER, SR | MARCH 21 2001 | 14:30 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| ST AGNES HEALTH CARE | BALTIMORE | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 219-18-1385 | 1☑M 2☐F | 18 Yrs. | | | ~~03-21-2001~~ 8-22-22 | MD |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | BALTIMORE | GWYNN OAK | 1☐Yes 2☑No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 4110 ETHLAND AVENUE | 21207 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☑Married 3☐Widowed 4☐Divorced | 1☐Yes 2☑No If Yes, Give Year or Dates: | 1☐Yes 2☑No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12TH GRADE | 8 YRS | LAWYER | LAW |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| LINWOOD KOGER, SR | RUTH WILSON |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| ALICE KOGER / WIFE | 4110 ETHLAND AVE., BALTO. MD. 21207 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☑Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | METRO CREMATORY | 03-24-01 | BALTO. MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Vaughn C Greene | VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL. PIKE, BALTO MD. 21229 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. SEPSIS | 1 day |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): URINARY TRACT INFECTION | 4 days |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ALZHEIMERS DEMENTIA

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☐No 3☐Probably 4☑Unknown | 1☐Yes 2☑No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☑No | Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] MD | 14445 | MARCH, 21, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
LOUISA APPEA-DANQUAH, 900 CATON AVE, BALTIMORE, MD

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 27 2001 | [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other trasumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

NAME O'NEAL W KOGER

01-1617-510
crn
Gopal Khetawat

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar **UNPENDED 101701: ITEMS #23a, 27, 28a-f** per MC G800 ss *Certificate of Death*

Reg. No. 2001 09253

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Gopal Khetawat | March 23 2001 | 9:27 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 2931 N. Calvert Street, 3rd Floor | Baltimore | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-51-4343 | 1 [X] M 2 [ ] F | 32 Yrs. | | | OCT 25, 1968 | India |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | N/A | Baltimore | 1 [X] Yes 2 [ ] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2931 N. Calvert Street | 21218 | India |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: | 1 [ ] Yes 2 [X] No Specify: | Specify: Asian Indian |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 5 + | Research Associate | John Hopkins |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Harish C. Khetawat | Ramkumari Bajoria |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Rina Khetawat/Wife | 2931 N. Calvert Street Baltimore, MD 21218 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Metro Crematory Inc. | 3-27-01 | Baltimore, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Edward A. Gregorchik | Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. PROBABLE INGESTION OF TOXIC SUBSTANCE | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1 [ ] Yes 2 [ ] No 9 [ ] Unknown | 1 [ ] Liva birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

BIPOLAR DISEASE

23e. Did tobacco use contribute to the causa of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 [✓] Yes 2 [ ] No | 1 [ ] Yes 2 [ ] No |

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) | |
|---|---|---|
| 1 [X] Yes 2 [ ] No | Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) at scene |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [X] Could not be determined | FOUND: 3-23-01 | FOUND: 9:27a M | 1 [ ] Yes 2 [X] No | Unknown |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| Residence | 2931 N. Calvert St, 3rd fl apt., Baltimore, MD |

29a. Certifier (Check only one)
1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Wayne Melzak | O.C.M.E. | March 24, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MD Lysnos D. Kokoris 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 27 2001 | Bernard G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

15

Spoke to F.H. 4/3 SS

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09254

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): George Kelly

2. Date of Death: Month 03 Day 24 Year 01

3. Time of Death: 9:20 AM

4a. Facility Name (If not institution, give street and number): 1610 Montpelier Ave.

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 238-50-7573

6. Sex: 1 ☑ M 2 ☐ F

7. Age (In yrs. last birthday): 65 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

6. Date of Birth (Month, Day, Year): 8-27-35

9. Birthplace (State or Foreign Country): SC

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☑ Yes 2 ☐ No

10e. Street and Number: 1610 Montpelier Ave.

10f. Zip Code: 21218

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 5th grade

College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): installer

16b. Kind of Business/Industry: Equipment Co.

17. Father's Name (First, Middle, Last): Ernest Kelly

18. Mother's Name (First, Middle, Maiden Surname): Elizzie McCall

19a. Informent's Neme/Relationship (Type, Print): Rosa Kelly

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1610 Montpelier Ave. Balto., MD 21218

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify)

20b. Piece of Disposition (Name of cemetery, crematory or other place): Mt. Zion

Date: 3/28/01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Patricia Butts

22. Name and Address of Facility: Butts Funeral Home 1529 N. Caroline St. Balto. Md 21213

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heert feilure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. Myocardial Infarction — SAME

Due to (or es a consequence of):

b. lung cancer — 2yr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted.

29b. Signatura end title of certifier: David Silver DO

29c. License number: #43234

29d. Date signed (Month, Day, Year): March 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID SILVER 3509 EASTERN AVE. Baltimore, MD 21224

**State Registrar**

31. Dete filed (Month, Day, Year): MAR 2 7 2001

32. Registrer's Signeture: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 09255

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Mary Kocun

2. Date of Death: Month: March Day: 24 Year: 2001

3. Time of Death: 12:35 AM

4a. Facility Name (If not institution, give street and number): Gilchrist Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 146-03-6335

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 4, 1914

9. Birthplace (State or Foreign Country): Michigan

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Towson

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 500 Virginia Ave., Apt. 707

10f. Zip Code: 21286

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker

16b. Kind of Business/Industry: own home

17. Father's Name (First, Middle, Last): George Lukacs

18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Sirakman

19a. Informant's Name/Relationship (Type, Print): Kenneth Kocun/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 525 Brook Rd. Towson, MD 21286

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Greenmount Crematory

Date: Mar. 26, 2001

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: John D. Mitchell IV

22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Rd. Baltimore, MD 21212

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. squamous cell cancer of tongue — Due to (or as a consequence of): — 3 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 8☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: A Anthony Riley, MD

29c. License number: D25205

29d. Date signed (Month, Day, Year): March 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W. A. Riley MD 6701 N. Charles St. Balto. md 21204

**State Registrar**

31. Date filed (Month, Day, Year): MAR 27 2001

32. Registrar's Signature: Edward B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

March 24, 2001 12:35 PM

MARY KOCUN

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

Amend Item#4a perPHYG794 4/23/01 EW
Amend Item#19a perFHG794 4/23/01 EW

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09256

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Mary Van Kirk

2. Date of Death Month March Day 24 Year 2001

3. Time of Death: 8:53 AM

4a. Facility Name (If not institution, give street and number): Anne Arundel Medical Center ~~Annapolis General Hospital~~

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel Co.

**Funeral Director**

5. Social Security Number: 218-03-4469

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 25 1918

9. Birthplace (State or Foreign Country): Illinois

Usual Residence of Decedent

10a. State: Md. | 10b. County: n/a | 10c. City, Town or Location: Baltimore | 10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1206 Sargeant Street | 10f. Zip Code: 21223 | 10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Factory Worker

16b. Kind of Business/Industry: Glass Crafter Co.

17. Father's Name (First, Middle, Last): George Doty

18. Mother's Name (First, Middle, Maiden Surname): Agnes Cole

19a. Informant's Name/Relationship (Type, Print): ~~Verinica~~ Veronica A. Hartley (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1058 Omar Drive, Crownsville, Md. 21032

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Bayview Crematory Inc. | Date: 3/26/2001

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: Richard Pickett

22. Name and Address of Facility: McCully-Polyniak Funeral Home. P.A. 237 E. Patapsco Ave. Baltimore, Md. 21225

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Acute Myocardial infarction | minutes |
| Due to (or as a consequence of): b. | Ischemic cardiomyopathy | Yrs |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): c. | Hypertensive Heart disease | Yrs. |
| Due to (or as a consequence of): d. | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: N. Javaheri M.D.

29c. License number: D41978

29d. Date signed (Month, Day, Year): 3-24-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Nader Javaheri M.D. 4000 Mitchellville Rd #312A Bowie M.D. 20716

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

**To Be Completed by Funeral Director**

**State Registrar**

31. Date filed (Month, Day, Year): MAR 27 2001

32. Registrar's Signature: Stephen G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09257

SS# 218-14-8049

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ANN M. KEIM

2. Date of Death: Month MARCH Day 21 Year 2001

3. Time of Death: 9:45PM

4a. Facility Name (If not institution, give street and number): GOOD SAMARITAN HOSPITAL.

4b. City, Town, or Location of Death: BALTIMORE.

4c. County of Death: BALTIMORE.

**Funeral Director**

5. Social Security Number: 218-14-8049

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 16 1923

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore Co.

10c. City, Town or Location: Towson

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 623 Stevenson Lane

10f. Zip Code: 21286

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Business Owner

16b. Kind of Business/Industry: Business Supply

17. Father's Name (First, Middle, Last): Louis W. Debus

18. Mother's Name (First, Middle, Maiden Surname): unknown

19a. Informant's Name/Relationship (Type, Print): Alison Layman (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 623 Stevenson Lane, Towson, Md. 21286

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Glen Haven Memorial Park

Date: 3/24/2001

20c. Location - City or Town, State: Glen Burnie, Md.

21. Signature of Funeral Service Licensee: Jamie Arthurs

22. Name and Address of Facility: McCully-Polyniak Funeral Home P.A. 130 E. Fort ave. Baltimore, Md. 21230

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. EMPHYSEMA.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: P-13456

29d. Date signed (Month, Day, Year): MARCH, 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SILVIA MUNOZ., GOOD SAMARITAN HOSPITAL, BALTIMORE

**State Registrar**

31. Date filed (Month, Day, Year): MAR 27 2001

32. Registrar's Signature: Sienna D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

01-1588-510
crm
Mark Levin

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

*Certificate of Death*

2001 09258
Reg. No.

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|
| MARK | LEVIN | March | 22 | 2001 | 6:01 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Sinai Hospital | Baltimore | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-52-1984 | 1 X M 2 ☐ F | 50 Yrs. | | | OCT.5,1950 | MD |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | N/A | BALTIMORE | 1 X Yes 2 ☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 6922 FIELDCREST ROAD | 21215 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 X No If Yes, Give Year or Dates: | 1 ☐ Yes 2 X No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 4 | SALES | LIQUOR |

| 17. Father's Name (First, Middle, Last) | | 18. Mother's Name (First, Middle, Maiden Surname) | |
|---|---|---|---|
| MAX | LEVIN | BEVERLY | KOHN |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| BEVERLY LEVIN / MOTHER | 6922 FIELDCREST ROAD - BALTIMORE, MD 21215 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | BETH TFILOH CEMETERY | 3/25/01 | WOODLAWN, MD |

21. Signature of Funeral Service Licensee: Mark Breiner

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

**Physician /Medical Examiner**

26. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Cardiac Arrhythmia | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. Arteriosclerotic Cardiovascular Disease | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1 ☐ Yes 2 X No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

Inspection

24a. Was an autopsy performed? 1 ☐ Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 X Yes 2 ☐ No

28. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1 ☐ Yes 2 ☐ No | 28d. Describe how injury occurred |
|---|---|---|---|
| | | | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Dennis J Chute MD | O.C.M.E. | March 22, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis Chute M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 2 7 2001 | Geneva G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09259

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Marguerite Elizabeth Linz
2. Date of Death (Month, Day, Year): March 25, 2001
3. Time of Death: 11:30pm
4a. Facility Name (If not institution, give street and number): Westminster Nursing & Rehabilitative Center
4b. City, Town, or Location of Death: Westminster
4c. County of Death: Carroll

**Funeral Director**

5. Social Security Number: 219-58-4918
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 5, 1908
9. Birthplace (State or Foreign Country): Baltimore, MD

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Reisterstown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1018 Nicodemus Rd
10f. Zip Code: 21136
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): William Rosensteel
18. Mother's Name (First, Middle, Maiden Surname): Lillie Rosensteel Hoke

19a. Informant's Name/Relationship (Type, Print): Robert E. Linz Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1018 Nicodemus Rd., Reisterstown, MD 21136

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Mem. Gardens
Date: 3/28/01
20c. Location - City or Town, State: Cockeysville, MD

21. Signature of Funeral Service Licensee: Karl B Eline
22. Name and Address of Facility: Eline Funeral Home, 11824 Reisterstown Rd. Reisterstown, MD 21136

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Ventricular Tachycardia — 4 min

Due to (or as a consequence of):
b. CAD — 15 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John Middleton
29c. License number: D25443
29d. Date signed (Month, Day, Year): 3-26-2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): John W Middleton 688 Rock Road, Westminster, Md 21157

**State Registrar**

31. Date filed (Month, Day, Year): MAR 2 7 2001
32. Registrar's Signature: Geneva G Sparks

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

01-1660-003
CRAIG GEORGE LAWTON
ASP

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM 23a,ptII,27 per ME G794 041001 SS

# Certificate of Death

2001 09260
Reg. No.

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Craig George Lawton

2. Date of Death: Month MARCH Day 24 Year 2001

3. Time of Death: 1518 M

4a. Facility Name (If not institution, give street and number): 8426 GARDEN RD

4b. City, Town, or Location of Death: PASADENA

4c. County of Death: ANNE ARUNDEL

**Funeral Director**

5. Social Security Number: 219 64 8484

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 47 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 20, 1953

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Pasadena

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 8426 Garden Road

10f. Zip Code: 21122

10g. Citizen of What Country?: U.S.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th
College (1-4or 5+):

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Self Employed

18b. Kind of Business/Industry: Automobile

17. Father's Name (First, Middle, Last): Jerry Lawton Jr.

18. Mother's Name (First, Middle, Maiden Surname): Gertrude Mary O'Rourke

19a. Informant's Name/Relationship (Type, Print): Jerry Lawton III / Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8426 Garden Road Pasadena, Maryland 21122

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Bayview Crematory, Inc.

Date: 3/28/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Sharon Liggett

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

If FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [✓] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

28. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [X] Other (Specify) SCENE

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Marjorie McCull

29c. License number: O.C.M.E

29d. Date signed (Month, Day, Year): MARCH 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): HARRIS A. KOREN 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): MAR 27 2001

32. Registrar's Signature: Bernice B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Amend Item#5 per FHG794 4/2/2001 EW

# Certificate of Death

Reg. No. 2001 09261

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Micheal E. Lyles
2. Date of Death (Month, Day, Year): March 21, 2001
3. Time of Death: 6:15AM
4a. Facility Name (If not institution, give street and number): Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 218-62-7245
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 47 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 8, 1954
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 1509 N. Potomac St. 2nd Floor
10f. Zip Code: 21213
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: African American

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Shipyard

17. Father's Name (First, Middle, Last): Emanuel Lyles
18. Mother's Name (First, Middle, Maiden Surname): Gladys Williams

19a. Informant's Name/Relationship (Type, Print): Mrs. Angela Lyles (wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1509 N. Potomac St. 2nd Floor Balto. Md. 21213

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Voshell Mem. Gardens | Date: 3/24/2001
20c. Location - City or Town, State: Dundalk, Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ
22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. DIFFUSE LARGE CELL LYMPHOMA — 5 MONTHS

Due to (or as a consequence of):
b. leptomeningeal lymphoma — 5 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Acquired Immune Deficiency Disease

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: Louis F. Diehl
29c. License number: D32671
29d. Date signed (Month, Day, Year): MARCH 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Louis F. Diehl Johns Hopkins Oncology, BALTIMORE, MD

**State Registrar**

31. Date filed (Month, Day, Year): MAR 2 7 2001
32. Registrar's Signature:

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09262

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Maria Pia Muscedere
2. Date of Death (Month, Day, Year): March 26 2001
3. Time of Death: 9:50am
4a. Facility Name (If not institution, give street and number): Multi Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 214-50-3202
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 57 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 2-10-1944
9. Birthplace (State or Foreign Country): Italy

Usual Residence of Decedent

10a. State: MD
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 12 N. Highland Avenue
10f. Zip Code: 21224
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker
16b. Kind of Business/Industry: In own home

17. Father's Name (First, Middle, Last): Silvio Gabriele
18. Mother's Name (First, Middle, Maiden Surname): Arcangela Tagliente

19a. Informant's Name/Relationship (Type, Print): son Michael Muscedere
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2308 Chetwood Circle, APt 203 Timonium, MD. 21093

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) Entomb.
20b. Place of Disposition (Name of cemetery, crematory or other place): Oaklawn Mausoleum
Date: 3/29/03
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Joseph N. Zannino Jr.
22. Name and Address of Facility: Joseph N. Zannino Jr. Funeral HM 263 S. Conkling St., Baltimore, Maryland 21224

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ASPIRATION .
Due to (or as a consequence of):
b. MUSCULAR DYSTROPHY .

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D52360
29d. Date signed (Month, Day, Year): 3/27/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ICUBIR SANDHU MD 1838 GREENE TREE RD SUITE 300 PIKESVILLE MD 21208

**State Registrar**

31. Date filed (Month, Day, Year): MAR 2 7 2001
32. Registrar's Signature: Geneva D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09263

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Nancy Emma Markins
2. Date of Death (Month, Day, Year): March 25, 2001
3. Time of Death: 4:05 PM
4a. Facility Name (If not institution, give street and number): Future Care Chesapeake
4b. City, Town, or Location of Death: Arnold
4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 215-40-2351
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUG 11, 1912
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1157 Washington Boulevard
10f. Zip Code: 21230
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): George Thompson
18. Mother's Name (First, Middle, Maiden Surname): Carrie Kelly

19a. Informant's Name/Relationship (Type, Print): Charles W. Markins/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 436 Hillview Drive, Apt. 303, Linthicum, MD 21090

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory, Inc.
Date: 3/26/01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Edward A. Gregerchak
Edward A. Gregerchak
22. Name and Address of Facility: Cremation Society of MD, Inc.
299 Frederick Road Baltimore, MD 21228

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Lung Disease of Unknown Primary — months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Alzheimer's dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M Dechoney MD
29c. License number: D-40521
29d. Date signed (Month, Day, Year): March 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR OCHANEY 3750 Wilkens Avenue Suite 302 Baltimore, MD 21229

**State Registrar**

31. Date filed (Month, Day, Year): MAR 2 7 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 09264

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Richard Jones Meeryman
2. Date of Death Month Day Year: March 25 2001
3. Time of Death: 6:30 PM
4a. Facility Name (If not institution, give street and number): 9636 Oak Summit Ave.
4b. City, Town, or Location of Death: Parkville
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 215-10-6703
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 16 1915
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md
10b. County: Baltimore
10c. City, Town or Location: Parkville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 9636 Oak Summit Ave.
10f. Zip Code: 21234
10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+): —
16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): truck driver
18b. Kind of Business/Industry: Texaco

17. Father's Name (First, Middle, Last): Milton C. Meeryman
18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Jones

19a. Informant's Name/Relationship (Type, Print): Linda Baker
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 134 Kensington Pkwy. Abingdon, Md 21009

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Moreland Mem. Park | Date: March 28 2001
20c. Location - City or Town, State: Parkville, Maryland

21. Signature of Funeral Service Licensee: Kenda L. Wells
22. Name and Address of Facility: Evans Funeral Chapel 8800 Harford Rd. Baltimore, Md 21234

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Stroke

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [X] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D0039297
29d. Date signed (Month, Day, Year): 3/26/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Michael Ro 2314 E. Joppa Rd. Baltimore, Md 21234

**State Registrar**

31. Date filed (Month, Day, Year): MAR 27 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

---

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09265

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): William H. McBroom
2. Date of Death Month/Day/Year: 3 / 21 / 01
3. Time of Death: 755 AM
4a. Facility Name (If not institution, give street and number): HCR Manor Care
4b. City, Town, or Location of Death: Towson MD
4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 843-32-2033
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): OCT-20, 1926
9. Birthplace (State or Foreign Country): NORTH CAROLINA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County:
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 5443 LYNVIEW AVE.
10f. Zip Code: 21215
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: W.W.II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 YRS. College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CUSTODIAN
16b. Kind of Business/Industry: EVANS FUNERAL CHAPEL

17. Father's Name (First, Middle, Last): WALTER WILLIAM MCBROOM
18. Mother's Name (First, Middle, Maiden Surname): LUCY VIRGINIA THOMAS

19a. Informant's Name/Relationship (Type, Print): MARIA MCBROOM
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5443 LYNVIEW AVE BALTIMORE, MARYLAND 21215

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): PAYNES CHAPEL A.M.E. CHURCH CEMETERY
Date: MARCH 27, 2001
20c. Location - City or Town, State: HILLSBOROUGH, NORTH CAROLINA
21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: EVANS CHAPEL OF CHIMES 2325 YORK ROAD TIMONIUM, MARYLAND 21093

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Metastatic prostate Cancer — >2 years

Due to (or as a consequence of):
b. H/O Colon Cancer — >2 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. C.V.A — >2 years

Due to (or as a consequence of):
d. H/O pulmonary Embolism — >2 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residance 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. Licensa number: D42736
29d. Date signed (Month, Day, Year): 3-21-01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 7600 Osler Drive - Towson 21204

**State Registrar**

31. Date filed (Month, Day, Year): MAR 27 2001
32. Registrar's Signature: D. Sparks

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09266

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Virginia M. Miller
2. Date of Death: Month March Day 25, Year 2001
3. Time of Death: 6:20PM
4a. Facility Name (If not institution, give street and number): Genesis Eldercare- Long Green Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 212-01-5506
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 86 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 14, 1914
9. Birthplace (State or Foreign Country): Virginia

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3416 Lyndale Avenue
10f. Zip Code: 21213
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Salesperson
16b. Kind of Business/Industry: Retail

17. Father's Name (First, Middle, Last): Henry Hynson
18. Mother's Name (First, Middle, Maiden Surname): Unknown

19a. Informant's Name/Relationship (Type, Print): Joshua Miller- Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1 Cormer Court Apt. 202 Timonium, MD 21093

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Service Corp.
Date: 3/27/01
20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: Heather Cain
22. Name and Address of Facility: Leonard J.Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediete Cause (Finel disease or condition resulting in death)
a. Failure to Thrive — weeks

Due to (or as a consequence of):
b. Senile Dementia Vascular Type — years

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.
Stroke
Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopay performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

**Medical Certification: To Be Completed by Physician/Medical Examiner**

25. Was case referred to medicet examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D17118
29d. Date signed (Month, Day, Year): MAR 26, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Paul Schwarz M.D 7700 York Rd 21204

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit copy.

**State Registrar**

31. Date filed (Month, Day, Year): MAR 27 2001
32. Registrar's Signature: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

RKD

01-1629-005

FRANKLIN MOYER SR.

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

## Certificate of Death

2001 09267 Reg. No.

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Franklin F. Moyer, Sr.
2. Date of Death Month: MARCH Day: 23, Year: 2001
3. Time of Death: 5:36P. M
4a. Facility Name (If not institution, give street and number): 7708 GREENSPRING AVE
4b. City, Town, or Location of Death:
4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 220-50-2364
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 51 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 4 1950
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md
10b. County: Baltimore
10c. City, Town or Location: Parkville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 2706 E. Joppa Rd.
10f. Zip Code: 21234
10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 College (1-4or 5+): —
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): self employed
16b. Kind of Business/Industry: painting Contractor

17. Father's Name (First, Middle, Last): Franklin P. Moyer
18. Mother's Name (First, Middle, Maiden Surname): Gloria A. SORRENTINO

19a. Informant's Name/Relationship (Type, Print): Evelyn G. Moyer
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2706 E. Joppa Rd. Baltimore, Md 21234

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Evans Funeral Chapel Bel Air Date: March 27 2001
20c. Location - City or Town, State: Forest Hill Md.

21. Signature of Funeral Service Licensee: Krista L. Wells
22. Name and Address of Facility: Evans Funeral Chapel 8800 Harford Rd. Baltimore, Md 21234

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR
Due to (or as a consequence of):
b. DISEASE
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [X] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) SCENE

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier: Nancy Mitchell MD
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Yaar): MARCH 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M.S. Pyapali R. KOREL 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): MAR 27 2001
32. Registrar's Signature: Jenna G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification; To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09268

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Eunice Alberta Mosher

2. Date of Death: Month MARCH Day 24 Year 2001

3. Time of Death: 12:45A.M.

4a. Facility Name (If not Institution, give street and number): FRANKLIN Square Hospital Center

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 360-07-8828

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 18, 1915

9. Birthplace (State or Foreign Country): Illinois

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Parkville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 8810 Walther Blvd.

10f. Zip Code: 21234

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): sales

16b. Kind of Business/Industry: department store

17. Father's Name (First, Middle, Last): Albert Brookhouse

18. Mother's Name (First, Middle, Maiden Surname): Lucy Smith

19a. Informant's Name/Relationship (Type, Print): William Mosher/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 18815 York Rd. Parkton, MD 21120

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Greenmount Crematory

Date: 3/26/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: John D. Mitchell IV

22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home, Inc 6500 York Rd. Baltimore, MD 21212

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure

Due to (or as a consequence of):

b. Myocardial Infarction

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 8☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dennis H. Odie MD

29c. License number: #192690

29d. Date signed (Month, Day, Year): March 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. DENNIS Odie, M.D.-9000 Franklin Square Drive-Baltimore, Maryland 21237

**State Registrar**

31. Date filed (Month, Day, Year): MAR 27 2001

32. Registrar's Signature: Bonnie G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Mosher, Eunice
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09269

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: William David McKiever
2. Date of Death Month / Day / Year: March 24 2001
3. Time of Death: 6:10 PM
4a. Facility Name *(If not institution, give street and number)*: Chesapeake Hospice Home
4b. City, Town, or Location of Death: Linthicum
4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 578-64-6733
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 50 Yrs. (If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.)
8. Date of Birth *(Month, Day, Year)*: May 18,1950
9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1516 Cypress Street
10f. Zip Code: 21226
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Assistant Manager
16b. Kind of Business/Industry: Superior Auto Paint

17. Father's Name *(First, Middle, Last)*: Unknown
18. Mother's Name *(First, Middle, Maiden Surname)*: Susan Gouldman

19a. Informant's Name/Relationship *(Type, Print)*: Jean McKiever ( Wife )
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1516 Cypress Street Baltimore, MD 21226

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Bayview Crematory
Date: 3/27/01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Donna M Zramiewski
22. Name and Address of Facility: Gonce Funeral Home, P.A. 4001 Ritchie Highway Baltimore, MD 21225

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Squamous Cell Carcinoma of the Lung — 14mos

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* Chesapeake Hospice House

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To be completed by Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: 031551
29d. Date signed *(Month, Day, Year)*: March 26,2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ward M. DeCury 1600 S. Cedar Highway Glen Burnie MD. 21061

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 26 2001
32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 09270

MICHAELS, MARY

Baltimore, Maryland 21215-0036

**Physician /Medical Examiner**

**Funeral Director**

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

1. Decedent's Name *(First, Middle, Last)*: Mary Martha Michaels

2. Date of Death Month / Day / Year: March 21 2001

3. Time of Death: 5:20pm

4a. Facility Name *(If not institution, give street and number)*: North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

5. Social Security Number: 213 28 4602

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Feb. 24, 1916

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Pasadena

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 104 Jackpine Drive

10f. Zip Code: 21122

10g. Citizen of What Country?: U.S.

11. Meritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: James Teevan

18. Mother's Name *(First, Middle, Maiden Surname)*: Ethel Mae Dickinson

19a. Informant's Name/Relationship *(Type, Print)*: Kathleen Fay

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 104 Jackpine Drive Pasadena, Maryland 21122

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Meadowridge Mem. Park

Date: 3/24/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Donna M Bramanscki

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Ventricular Tachycardia

Due to (or as a consequence of):

Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypokalemia

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease, Emphysema, COPD, Heart failure, Diab. Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Reagan

29c. License number: D31344

29d. Date signed *(Month, Day, Year)*: 3/21/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PRADEEP GARGOND 4304 MTN. RD, PASADENA, Md 21122.

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 26 2001

32. Registrar's Signature

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed [illegible] hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit [illegible].

**Division of Vital Records, P.O. Box 68760,**

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2001 09271

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: James Kenard Nolte, Sr.

2. Date of Death (Month, Day, Year): March 21, 2001

3. Time of Death: 10:10 am

4a. Facility Name *(If not institution, give street and number)*: Stella Maris Hospice

4b. City, Town, or Location of Death: Timonium

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 213-14-9824

6. Sex: 1☒ M 2☐ F

7. Age *(in yrs. last birthday)*: 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec. 27 1922

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Timonium

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 8 Roundridge Rd.

10f. Zip Code: 21093

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: '43-'46

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Estimator

16b. Kind of Business/Industry: Government

17. Father's Name *(First, Middle, Last)*: Bernard F. Nolte

18. Mother's Name *(First, Middle, Maiden Surname)*: Eleanor B. Slate

19a. Informant's Name/Relationship *(Type, Print)*: Eleanor H. Nolte/wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8 Roundridge Rd., Timonium, MD 21093

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Dulaney Valley Memorial Gardens

Date: 3/24/01

20c. Location - City or Town, State: Timonium, MD 21093

21. Signature of Funeral Service Licensee: Lowell M. Lemmon

22. Name and Address of Facility: Lemmon Funeral Home, 10 W. Padonia Rd., Timonium, MD 21093

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-i show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. LUNG CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* HOSPICE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D43725

29d. Date signed *(Month, Day, Year)*: 3/21/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 2 7 2001

32. Registrar's Signature

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

MARCH 21, 2001 10:10 a.m.

JAMES NOLTE

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 09272

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Mildred McCrea Nagell

2. Date of Death: Month March, Day 23, Year 2001

3. Time of Death: 12:20p M

4a. Facility Name (If not institution, give street and number): 117 Castlewood Road

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 213-74-2255

8. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 101 Yrs.

If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): November 3, 1899

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 117 Castlewood Road

10f. Zip Code: 21210

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk

16b. Kind of Business/Industry: Banking

17. Father's Name (First, Middle, Last): Jessie L. McCrea

18. Mother's Name (First, Middle, Maiden Surname): Bridget Nertney

19a. Informant's Name/Relationship (Type, Print): Timothy McManus (Nephew)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 882 Easton, Maryland 21601

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Cross Cemetery

Date: 3/27/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Steven T. Little

22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, MD 21212

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Mark Stromberg MD

29c. License number: D32543

29d. Date signed (Month, Day, Year): 3/26/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARK STROMBERG 6701 N. Charles St Baltimore MD

**State Registrar**

31. Date filed (Month, Day, Year): MAR 27 2001

32. Registrar's Signature: Bernice B Spinks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Attending Physician or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09273

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): CINDERELLA IMOGENE NATHAN
2. Date of Death: Month MARCH Day 21, Year 2001
3. Time of Death: 11:40 P.M.
4a. Facility Name (If not institution, give street and number): JOSEPH RICHEY HOSPICE
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 218-59-8594
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 8/3/24
9. Birthplace (State or Foreign Country): JAMAICA

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: HILLENDALE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1352 HALSTEAD ROAD
10f. Zip Code: 21234
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH GRADE; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SECRETARY
16b. Kind of Business/Industry: SANITATION DEPT.

17. Father's Name (First, Middle, Last): GEORGE NATHAN
18. Mother's Name (First, Middle, Maiden Surname): ELIZABETH DUHANEY

19a. Informant's Name/Relationship (Type, Print): LORNA THOMAS DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1352 HALSTEAD ROAD BALTIMORE, MD 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MORELAND MEMORIAL PARK
Date: 3/24/01
20c. Location - City or Town, State: HILLENDALE, MD

21. Signature of Funeral Service Licensee: M. Leaf Coleman
22. Name and Address of Facility: THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Physician /Medical Examiner**

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Carcinoma of bladder with mets <1yr

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: John Payne MD
29c. License number: D 13012
29d. Date signed (Month, Day, Year): Mar 22, 01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John Payne 6565 N. Charles St 21204

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Cinderella Nathan 3-21-01 11:40 pm

**State Registrar**

31. Date filed (Month, Day, Year): MAR 27 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09274

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Physician /Medical Examiner**

**Funeral Director**

**To Be Completed by Funeral Director**

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**State Registrar**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 1. Decedent's Name (First, Middle, Last): MARCIA NEWMAN | | | | | 2. Date of Death: Month MARCH, Day 22, Year 2001 | | | 3. Time of Death: 1150 AM |
| 4a. Facility Name (If not institution, give street and number): MERCY MEDICAL CENTER | | | 4b. City, Town, or Location of Death: BALTIMORE | | | 4c. County of Death: BALTIMORE CITY | | |
| 5. Social Security Number: 212-36-0273 | 6. Sex: 1☐ M 2☒ F | 7. Age (In yrs. last birthday): 62 Yrs. | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min. | 8. Date of Birth (Month, Day, Year): July 01 1938 | 9. Birthplace (State or Foreign Country): Maryland |
| Usual Residence of Decedent | | | | | | | | |
| 10a. State: Md. | 10b. County: Anne Arundel Co. | 10c. City, Town or Location: Baltimore | | | | | 10d. Inside City Limits: 1☐ Yes 2☒ No | |
| 10e. Street and Number: 412 Cresswell Road | | 10f. Zip Code: 21225 | | | | | 10g. Citizen of What Country? USA | |
| 11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced | 12. Wes Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify: | | | | | 14. Race - American Indian, Black, White, etc. Specify: white | |
| 15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4or 5+): 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife | | | | | 16b. Kind of Business/Industry: Home Owner | |
| 17. Father's Name (First, Middle, Last): Maurice Fitzhugh | | | | | 18. Mother's Name (First, Middle, Meiden Surname): Violet S. Price | | | |
| 19a. Informant's Name/Relationship (Type, Print): Gene S. Newman (Husband) | | 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 412 Cresswell Road, Baltimore, Md. 21225 | | | | | | |
| 20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | | 20b. Place of Disposition (Name of cemetery, cremetory or other piece): Glen Haven Memorial Park | | | Date: 3/26/2001 | | 20c. Location - City or Town, State: Glen Burnie, Md. | |
| 21. Signature of Funeral Service Licensee: Richard Puckett | | 22. Name end Address of Facility: McCully-Polyniak Funeral Home P.A. 130 E. Fort ave. Baltimore, Md. 21230 | | | | | | |

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one ceuse on eech line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immedlete Cause (Final disease or condition resulting in death) | a. Non Small Cell Lung Carcinoma | 3 months |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yas 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of *my* knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, In *my* opinion, death occurred at the time, date end place, and due to tha cause(s) and manner stated.

| 29b. Signature end title of certifier | 29c. License number | 29d. Data signed (Month, Day, Year) |
|---|---|---|
| Marvin Jack Feldman MD | D07930 | March 22, 2001 |

30. Name and address of person who completed cause ot death (Item 23a) (Type, Print): Marvin Jack Feldman MD 301 St. Paul Place Baltimore MD 21202

| 31. Data filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 27 2001 | G. Sparks |

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

ADMEND ITEM: #2 PER PHY G793 3-27-01 WR.

# Certificate of Death

Reg. No. 2001 09275

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Joseph Orlovich

2. Date of Death Month 2 Day 21 Year 01

3. Time of Death 9:10 Am

4a. Facility Name (If not institution, give street and number): Mayo of Bethesda

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 175 145 103

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 9/12/22

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Bethesda

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 5721 Grosvenor Road

10f. Zip Code: 20814

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): truck driver

16b. Kind of Business/Industry: towing

17. Father's Name (First, Middle, Last): Joseph Orlovich Sr

18. Mother's Name (First, Middle, Maiden Surname): Agnes G. Rosemarich

19a. Informant's Name/Relationship (Type, Print): Josephine Orlovich/spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 22 Ridge Rd #301 Greenbelt, MD 20770

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place):

Date:

20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. small cell carcinoma of lung

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Elliot L Goldstein MD

29c. License number: D03581

29d. Date signed (Month, Day, Year): February 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Elliot Goldstein, 9440 Old Georgetown Road, Bethesda, Maryland 20814

**State Registrar**

31. Date filed (Month, Day, Year): MAR 2 7 2001

32. Registrar's Signature: B Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg.No. 2001 09276

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): DOROTHY CATHERINE O'NEILL
2. Date of Death (Month, Day, Year): MARCH 24, 2001
3. Time of Death: 06:55 AM
4a. Facility Name (If not institution, give street and number): GENESIS ELDER CARE
4b. City, Town, or Location of Death: SEVERNA PARK
4c. County of Death: ANNE ARUNDEL

**Funeral Director**

5. Social Security Number: 215-01-1668
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JUNE 14, 1914
9. Birthplace (State or Foreign Country): MARYLAND

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: CROWNSVILLE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1115 SEVERNVIEW DRIVE
10f. Zip Code: 21032
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CROSSING GUARD
16b. Kind of Business/Industry: ANNE ARUNDEL CO. POLICE DEPT.

17. Father's Name (First, Middle, Last): WALTER JACKSON
18. Mother's Name (First, Middle, Maiden Surname): MATILDA HENNLEIN

19a. Informant's Name/Relationship (Type, Print): MICHAEL T. O'NEILL (SON)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1115 SEVERNVIEW DRIVE, CROWNSVILLE, MARYLAND 21032

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GLEN HAVEN MEMORIAL PARK | Date: 03/28/2001
20c. Location - City or Town, State: GLEN BURNIE, MD

21. Signature of Funeral Service Licensee: R. George Hopkins
22. Name and Address of Facility: SINGLETON FUNERAL HOME, P.A. 1 SECOND AVE. S.W., GLEN BURNIE, MD 21061

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errast, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Coronary Artery Disease
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Hypertension
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I: Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: M.D
29c. License number: D 50470
29d. Date signed (Month, Day, Year): 03/26/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. SRIDHAR ATLURI 1319 LIGHT STREET, BALTIMORE, MARYLAND 21230

**State Registrar**

31. Date filed (Month, Day, Year): MAR 2 7 2001
32. Registrar's Signature: Penne G Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09277

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Paul F. Palmieri

2. Date of Death: Month March Day 24, Year 2001

3. Time of Death: 6:45am

4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: n/a

**Funeral Director**

5. Social Security Number: 220-03-2963

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 79 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10/17/1921

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 422 S. Bouldin Street

10f. Zip Code: 21224

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Chauffeur

16b. Kind of Business/Industry: Esskay

17. Father's Name (First, Middle, Last): Gregory Palmieri

18. Mother's Name (First, Middle, Maiden Surname): Annunciata Calzonetta

19a. Informant's Name/Relationship (Type, Print): wife Helen Palmieri

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 422 S. Bouldin St., Baltimore, Maryland 21224

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) entomb.

20b. Place of Disposition (Name of cemetery, crematory or other place): Oakland Mausoleum

Date: 3/27/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Joseph N Zannino Jr.

22. Name and Address of Facility: Joseph N. Zannino Jr. Funeral Hm. 263 S. Conkling St., Baltimore, Maryland 21224

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

b. Coronary Artery Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cerebro Vascular disease
Renal Failure

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D15734

29d. Date signed (Month, Day, Year): 3/26/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): STEVEN SCHNEIDMAN MD 3509 Eastern Avenue Balto 21224

**State Registrar**

31. Date filed (Month, Day, Year): MAR 2 7 2001

32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item#17,19b per FHG793 3/27/01 **Certificate of Death** Reg. No. 2001 09278

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|
| FANNIE | PAISNER | MARCH 23, 2001 | 6:05 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| JEWISH CONVALESCENT & NURSING HOME | BALTIMORE | BALTIMORE |

**Funeral Director**

| 5. Social Security Number | 8. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 089-10-7866 | 1☐ M 2☒ F | 83 Yrs. | | | OCT. 6, 1917 | N.Y. |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | HOWARD | COLUMBIA | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 6805 CARAVAN COURT | 21044 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | HOMEMAKER | OWN HOME |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| WILLIAM Schevinsky ~~SHEVINSKY~~ | REBECCA SCHEVINSKY |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| MARTIN PAISNER / SON | 6805 ~~6905~~ CARAVAN COURT - COLUMBIA, MD 21044 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify) | BETH DAVID MEMORIAL GARDENS | 3/26/01 | HOLLYWOOD, FL |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Edward C. Rund | SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Atherosclerotic cardiovascular disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | N/A | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ MD | D15872 | March 23, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
HAROLD B BUB 25 Main Street Reisterstown Maryland 21136

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 27 2001 | ▶ Geneva B Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 09279

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): CATHERINE LOUISE PAYE
2. Date of Death (Month, Day, Year): Mar 24 2001
3. Time of Death: 20:48 PM
4a. Facility Name (If not institution, give street and number): Howard County General Hospital
4b. City, Town, or Location of Death: Jessup
4c. County of Death: Howard

**Funeral Director**

5. Social Security Number: 212-42-9898
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 55 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 22, 1945
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Jessup
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 7970 Jones Road Route 32
10f. Zip Code: 20794
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: African American

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+): 4+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Care worker
16b. Kind of Business/Industry: Tiny Tots

17. Father's Name (First, Middle, Last): Leon Clark
18. Mother's Name (First, Middle, Maiden Surname): Estelle Beck

19a. Informant's Name/Relationship (Type, Print): Lonnie Paye Sr - Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7970 Jones Road Route 32 Jessup, Maryland 20794

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): First Bapt. Church Memorial Park
Date: 3/31/01
20c. Location - City or Town, State: Jessup, Maryland

21. Signature of Funeral Service Licensee: Nancy M. Wallace
22. Name and Address of Facility: Nancy M. Wallace Funeral Service 3405 W. Franklin Street - Baltimore, Maryland 21229

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Ventricular arrhythmia — seconds

Due to (or as a consequence of):
b. Dilated Cardiomyopathy — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Atherosclerotic Cardiovascular Disease — years

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Chronic Obstructive Pulmonary Disease, Obesity, S/P Open Heart Surgery 1976- bypass

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Patricia A. Toye MD Deputy ME
29c. License number: D31473
29d. Date signed (Month, Day, Year): March 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PATRICIA A. TOYE, MD 4565 Hemlock Cone Way Ellicott City MD 21042

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

16

**State Registrar**

31. Date filed (Month, Day, Year): MAR 27 2001
32. Registrar's Signature: Barbara G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No: 2001 09280

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen M. Penn

2. Date of Death: Month March, Dey 23, Year 2001

3. Time of Death: 2:15 A.M.

4a Facility Name (If not institution, give street and number): Mariner Health of Glen Burnie

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 212 05 5080

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): Dec. 7, 1909

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Pasadena

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1522 Marco Drive

10f. Zip Code: 21122-4839

10g. Citizen of What Country? U.S.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own HOme

17. Father's Name (First, Middle, Last): William Wagner

18. Mother's Name (First, Middle, Maiden Surname): Johanna

19a. Informant's Name/Relationship (Type, Print): Frank Kaiss Jr. / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1522 Marco Drive Pasadena, Maryland 21122

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery

Date: 3/26/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Sharon Liggett

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Old age.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Dementia — 5years.

Due to (or as a consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Attending Physician MD

29c. License number: D44973

29d. Date signed (Month, Day, Year): March 23 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GURMEET S SAWHNEY MD 325 HOSPITAL DRIVE 202, GLEN BURNIE MD 21061.

State Registrar

31. Date filed (Month, Day, Year): MAR 2 6 2001

32. Registrar's Signature: Jeanne B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

AMEND#3,21&29d PER MD. G793 3-27-2001 JAB **Certificate of Death**

Reg. No. 2001 09281

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| Baby | A. | Rothering | February 5, 2001 | 12:41 pm |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Greater Baltimore Medical Center | Towson | Maryland |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 111-11-1111 | 1☒M 2☐F | Yrs. | | | 10 02/05/2001 | Maryland |

**To Be Completed by Funeral Director**

Usual Residance of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Baltimore | Reisterstown | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 237 Pidco Road | 21136 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forcas? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒Never Married 2☐Married 3☐Widowed 4☐Divorcad | 1☐Yes 2☒No If Yes, Give Year or Detes: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| N/A | N/A | N/A | |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| David Rothering | Kelly Brant |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Nikki Chilcoat (Staff) | GBMC, 6701 N. Charles St., Towson, MD., 21204 |

| 20a. Mathod of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Deta | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Green Mount Crematory | 2-8 | Baltimore, MD., 21202 |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ R.G. RUTH ( PER D.V.R. ) | Henry W. Jenkins and Sons Company 6500 York Road, Baltimore, MD., 21212 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Cardiac arrest | |
| | Dua to (or as a consequance of): | |
| Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avants resulting in death) Last | b. Prematurity | 10 mins |
| | Dua to (or as a consaquance of): | |
| | c. Premature labor and P.R.O.M | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpetient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Othar (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be datarmined | | M | 1☐Yes 2☐No | |
| | 28a. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) | | | 26f. Location (Street and Number or Rural Route Number, City or Town, State) |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | D22188 | 2/5/2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kamal A. Hamod, M.D.; Johns Hopkins Greenspring Lutherville, 21093

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 2 7 2001 | [signature] G Sparks |

DHMH 16 Rev 6/95

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09282

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): CATHERINE Ruby

2. Date of Death: Month MARCH Day 24 Year 2001

3. Time of Death: 04:20 PM

4a. Facility Name (If not institution, give street and number): HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 219-05-1746

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): DEC 3, 1920

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3120 Stafford Street

10f. Zip Code: 21229

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): UNK.

18. Mother's Name (First, Middle, Maiden Surname): UNK.

19a. Informant's Name/Relationship (Type, Print): Vernon Ruby, Sr./Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3120 Stafford Street Baltimore, MD 21229

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Inc.

Date: 3-26-01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Thomas Gregor

22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):

a. ACUTE RESPIRATORY FAILURE — two weeks

Due to (or as a consequence of):

b. SEPTIC SHOCK

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. PNEUMONIA

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: V. Galabova

29c. License number: RES 000

29d. Date signed (Month, Day, Year): MARCH 24 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): VIOLETA GALABOVA, MD HARBOR HOSPITAL CENTER, 3001 S. HANOVER ST, BALTIMORE, MD

**State Registrar**

31. Date filed (Month, Day, Year): MAR 27 2001

32. Registrar's Signature: B Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09283

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): LORRAINE T. REDEL
2. Date of Death (Month, Day, Year): MARCH 18, 2001
3. Time of Death: 7:00 AM
4a. Facility Name (If not institution, give street and number): 7848 AMERICANA CIRCLE, #203
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: ANNE ARUNDEL

**Funeral Director**

5. Social Security Number: 212-18-3514
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): OCT. 4, 1919
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: GLEN BURNIE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7848 AMERICANA CIRCLE, #203
10f. Zip Code: 21060
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SECRETARY
16b. Kind of Business/Industry: ELECTRIC PORCELAIN INSULATORS MFGR.

17. Father's Name (First, Middle, Last): GEORGE REDEL
18. Mother's Name (First, Middle, Maiden Surname): SADIE MILLER

19a. Informant's Name/Relationship (Type, Print): RUBY HARDING (FRIEND)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4 HAMPTON ROAD, LINTHICUM, MD. 21090

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CHESAPEAKE CREMATION CENTER, LLC. STEVENSVILLE, MD.
Date: 3/21/2001
20c. Location - City or Town, State
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Sudden cardiac death
Due to (or as a consequence of):
b. Stroke
Due to (or as a consequence of):
c. Hypertension
Due to (or as a consequence of):
d. Diabetes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)
27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D25654
29d. Date signed (Month, Day, Year): 3/20/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): YEONG OH 142 CRAIN HWY N GLEN BURNIE MD

**State Registrar**

31. Date filed (Month, Day, Year): MAR 27 2001
32. Registrar's Signature: [signature] G Sparks

Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

01-1646-005
mnmr
Mary Roe

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 09284

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| MARY | L. | ROE | March 24, 2001 | 748 a M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Atlantic Cleaners, 870 Walker Avenue | Towson | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-44-4027 | 1☐M 2☒F | 56 Yrs. | | | JAN. 22, 1945 | MARYLAND |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | ANNE ARUNDEL | SEVERN | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1324 PAUL DRIVE | 21144 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 9 | | MANAGER | DRY CLEANER |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| KENNETH DAVIDSON | MARIE BOWERS |

| 19a. Informent's Name/Reletionship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| MR. ROBERT ROE, SR. (HUSBAND) | 1324 PAUL DRIVE, SEVERN, MARYLAND 21144 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, cremetory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | CHEASPEAKE CREMATION, LLC. | 3/27/2001 | STEVENSVILLE, MD. |

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

**Physician /Medical Examiner**

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Finel disease or condition resulting in death) | a. Multiple Stab and Cutting Wounds | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnent in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnent at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☒Yes 2☐No | 1☒Yes 2☐No |

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) | | | | | | |
|---|---|---|---|---|---|---|---|
| 1☒Yes 2☐No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) at scene | | | | | |

| 27. Manner of Death | 28e. Date of Injury (Month, Day, Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☐Natural 2☐Accident 3☐Suicide 4☒Homicide 5☐Pending investigation 6☐Could not be determined | 3-24-01 | 740 A M | 1☒Yes 2☐No | subject stabbed and cut |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| building | 870 Walker Ave Towson, Md |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Dennis J Cluten | O.C.M.E. | March 25, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis Chutenco 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 27 2001 | ▶ [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09285

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Elnora Sellers

2. Date of Death Month: March Day: 20th Year: 2001

3. Time of Death: 12 20 P

4a. Facility Name *(If not institution, give street and number)*: BON SECOURS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 215-22-5562

6. Sex: 1☐ M 2☑ F

7. Age *(In yrs. last birthday)*: 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 08-19-1920

9. Birthplace *(State or Foreign Country)*: SC

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: GWYNN OAK

10d. Inside City Limits: 1☐ Yes 2☑ No

10e. Street and Number: 2121 WINSOR GARDEN LANE #205

10f. Zip Code: 21207

10g. Citizen of What Country?: USA

11. Meritel Stetus: 1☐ Nevar Married 2☐ Married 3☑ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yas 2☑ No If Yas, Giva Year or Dates:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yas 2☑ No *Specify:*

14. Race - American Indian, Bleck, Whita, atc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 3 RD GRADE; College (1-4or 5+): N/A

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: COOK

16b. Kind of Business/Industry: FOOD SERVICE

17. Fathar's Nama *(First, Middle, Last)*: MAYS GILMORE

18. Mothar's Nama *(First, Middle, Maiden Surname)*: ROSALEE WASHINGTON

19a. Informant's Name/Relationship *(Type, Print)*: MARGUERITE CAMPBELL

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2307 WINCHESTER ST. BALTO. MD 21216

20a. Mathod of Disposition: 1☑ Burial 2☐ Cremation 3☐ Ramoval from Stata 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: KING MEMORIAL PARK

Date: 3/26/01

20c. Location - City or Town, State: RANDALLSTOWN, MD

21. Signeture of Funerel Servica Licensee: Vaughn C Greene

22. Nama and Addrass of Facility: VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL PIKE, BALTO. MD. 21229

**Physician /Medical Examiner**

23a. Part1. Entar the diseasa, or complications that caused tha daath. Do not entar tha moda of dying, such as cardiac or respiratory arrast, shock, or haart failure. List only ona causa on aach lina.

Approximata Intarval Batwaen Onsat and Daath

Immediata Ceusa (Finat disaasa or condition resulting in death)

a. Coronary artery disease

Due to (or as a consequence of):

b. Congestive heart failure

Sequentially list conditions, if any, leading to immediata causa. Entar Underlying Cause (Disease or injury that initiated evants resulting in death) Last

Due to (or as a consequence of):

c. Hypertension

Due to (or as a consequence of):

d. Diabetic mellitus

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Cardio-pulmonary arrest.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yas 2☒ No

25. Was casa rafarrad to medical examinar? 1☐ Yas 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Othar *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be determined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledge, daath occurred at tha tima, data and place, end due to tha causa(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, deeth occurred at tha time, date and place, and due to tha cause(s) and mannar stated.

29b. Signature and title of certifier

29c. License number: D30115

29d. Data signed *(Month, Day, Year)*: 3/2011

30. Nama and addrass of person who completed causa of daath (Item 23a) (Type, Print): T. Ohiok Pehsimo 2600 Liberty Hgts Ave Baltimore MD 21215

**State Registrar**

31. Data filed *(Month, Day, Year)*: MAR 2 7 2001

32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 09286

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Jeannette Virginia Smith

2. Date of Death Month March Day 26, Year 2001

3. Time of Death: 1:15a M

4a. Facility Name *(If not institution, give street and number)*: Noble House

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 124-07-0794

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 88 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Apr 04, 1912

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 11 W. 20th Street Apt. 14K

10f. Zip Code: 21218

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housekeeper

18b. Kind of Business/Industry: Domestic

17. Father's Name *(First, Middle, Last)*: Wilbert Scott

18. Mother's Name *(First, Middle, Maiden Surname)*: Mollie Scott

19a. Informant's Name/Relationship *(Type, Print)*: Gilbert S. Cole (Son) Step

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3325 Ingleside Avenue Baltimore, Maryland 21215

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Garrison Forest Vet

Date: 03/30/01

20c. Location - City or Town, State: Owings Mills, Maryland

21. Signature of Funeral Service Licensee: Dennis B. Cole

22. Name and Address of Facility: Dennis B. Caple Funeral Home, P.A. 4601 York Road Baltimore, Maryland 21212

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. End Stage Zenal Disease

Due to (or as e consequence of):

Hypertension

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as e consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other *(specify)* 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. Dthar significant conditions contributing to death but not resulting in the underlying ceuse givan in Part I.

Hyo Bacteremia

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Yeer)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier: D Sahay

29c. License number: D17537

29d. Date signed *(Month, Day, Year)*: 3-26-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DARSHAN S. SALUJA MD 1600 W. MOUNT Royal Ave, Balto 21217

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 27 2001

32. Registrar's Signature: [illegible] Sparks

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification; To Be Completed by Physician/Medical Examiner**

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09287

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Gloria . Savage

2. Date of Death — Month: March; Day: 20; Year: 2001

3. Time of Death: 0420

4a. Facility Name *(If not institution, give street and number)*: Sinai Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore City

**Funeral Director**

5. Social Security Number: 223-68-7667

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 53 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 11 24 47

9. Birthplace *(State or Foreign Country)*: V.A.

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1004 West Franklin Street

10f. Zip Code: 21223

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th grade; College (1-4or 5+): 2 yrs

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Telephone Operator

16b. Kind of Business/Industry: Sinai Hospital

17. Father's Name *(First, Middle, Last)*: Charlie Hutcheson

18. Mother's Name *(First, Middle, Maiden Surname)*: Thelma Watkins

19a. Informant's Name/Relationship *(Type, Print)*: Nakia Darden-Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1004 West Franklin Street, Baltimore Md 21223

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Woodlawn Cemetery — Date: 3/24/01

20c. Location - City or Town, State: Baltimore Co, Md

21. Signature of Funeral Service Licensee: Barry R. Thompson

22. Name and Address of Facility: March F/H West, 4300 Wabash Ave, Baltimore Md 21215

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic carcinoma — 5 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD Resident, Orthopedic Surgery

29c. License number

29d. Date signed *(Month, Day, Year)*: March, 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Harrison Solomon, M.D. 22 South Greene St Baltimore, Maryland

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 2 7 2001

32. Registrar's Signature: Donna G. Sparks

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 09288

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: WILBERT SMITH JR

2. Date of Death — Month: MARCH Day: 26 Year: 2001

3. Time of Death: 10 41

4a. Facility Name *(If not institution, give street and number)*: SINAI HOSPITAL OF BALTIMORE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 239-60-4412

6. Sex: 1 ☑ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 59 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: OCT. 7, 1941

9. Birthplace *(State or Foreign Country)*: N. Carolina

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☑ Yes 2 ☐ No

10e. Street and Number: 4727 Williston St.

10f. Zip Code: 21229

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12th — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Machine Operator

16b. Kind of Business/Industry: Factory

17. Father's Neme *(First, Middle, Last)*: Wilbert Smith

18. Mother's Neme *(First, Middle, Maiden Surname)*: Elnora Barton

19a. Informent's Neme/Reletionship *(Type, Print)*: Amie L. Smith

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 4727 Williston St. Balto., MD. 21229

20a. Method of Disposition: 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, crematory or other piece)*: Metro Crematory

Date: 3-31-01

20c. Location - City or Town, State: Catonsville, MD.

21. Signature of Funerel Service Licensee: Carol F. March

22. Neme and Address of Facility: Gary R March Funeral Home P.A. 2710 Freshilton Pass Balto, MD 21229

**Physician /Medical Examiner**

23a. Part I. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory erfest, shock, or heart failure. List *only one* ceuse on eech line.

Approximete Interval Between Onset end Deeth

Immediate Cause (Final diseese or condition resulting in deeth)

a. MULTIORGAN SYSTEM FAILURE — TEN DAYS

Due to (or as a consequence of):

b. CHRONIC RENAL FAILURE

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Last

Due to (or es e consequence of):

c. CEREBRO VASCULAR ACCIDENT

Due to (or es e consequence of):

d. CORONARY ARTERY DISEASE

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Wes case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Piece of Deeth *(Check only one)*: Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Deeth: 1 ☒ Netural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner steted.

29b. Signeture and title of certifier: A J Sequeira

29c. License number: D0014726

29d. Date signed *(Month, Day, Year)*: MARCH 26 2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): A. J. SEQUEIRA, M.D. 2401 W. BELVEDERE, BALTIMORE, MD.

**State Registrar**

31. Dete filed *(Month, Day, Year)*: MAR 2 7 2001

32. Registrer's Signature: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09289

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Margaret B. Smith

2. Date of Death Month / Day / Year: March 23, 2001

3. Time of Death: 4:40 PM

4e. Facility Name *(If not institution, give street and number)*: Sinai Hospital of Baltimore

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 219-10-9934

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 87 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec. 16, 1913

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2211 West Rogers Ave.

10f. Zip Code: 21209

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): Unknown

College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: In Own Home

17. Father's Name *(First, Middle, Last)*: Thomas Bond

18. Mother's Name *(First, Middle, Maiden Surname)*: Jane Mays

19a. Informant's Name/Relationship *(Type, Print)*: Lynne Roberts (Granddaughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10 Chesham Ct. Cockeysville, Md 21030

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Lorraine Park Cemetery

Date: 3/26

20c. Location - City or Town, State: Balto, MD

21. Signature of Funeral Service Licensee: Michael Carpenter

22. Name and Address of Facility: Burger-Hens-Seitz Funeral Home, Inc. 3631 Falls Rd. Balto, MD 21211

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

b. Coronary artery Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic Renal Insufficiency.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*

Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: R. Liberto, MD.

29c. License number: D21764

29d. Date signed *(Month, Day, Year)*: 3/26/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROBERT LIBERTO, MD. 3508 BANK ST. BALTO, Md 21224

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 27 2001

32. Registrar's Signature: Frances G Sparks

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Margaret B Smith

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09290

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Margaret Schiebel
2. Date of Death Month Day Year: March 24, 2001
3. Time of Death: 9:15 PM

4a. Facility Name *(If not institution, give street and number)*: Levindale Rehabilitation Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: A.A.

**Funeral Director**

5. Social Security Number: 215-05-1901
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 93 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 27, 1907
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 5255 Linden Heights Avenue
10f. Zip Code: 21215
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Rece - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest greda completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Telephone Operator
16b. Kind of Business/Industry: C & P Telephone Company

17. Father's Name *(First, Middle, Last)*: (unk) Rudisill
18. Mother's Name *(First, Middle, Maiden Surname)*: Ella Bond

19a. Informant's Name/Relationship *(Type, Print)*: Ruth Freburger Daughter-in-Law
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 18 E. Green Valley Circle; Newark, Delaware 19711

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cematary, cremetory or other piece)*: Lorraine Park Cemetery
Date: 4/3/01
20c. Location - City or Town, State: Woodlawn, Maryland

21. Signature of Funeral Servica Licensee: [signature] M0086
22. Name and Address of Facility: Loring Byers Funeral Directors, Inc. 8728 Liberty Road; Randallstown, Maryland 21133

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complicationa thet caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory erreat, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disaasa or condition resulting in deeth)
a. Sepsis
Due to (or es a consequence of):
b. Urinary tract infection
Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last
Due to (or es a consequenca of):
c. Cerebrovascular accident
Due to (or as a consequenca of):
d. Hypertension

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uas contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findinga available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Piece of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Othar *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28e. Placa of Injury - At home, ferm, street, factory, offica building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of *my* knowledge, death occurred et the time, date end placa, end due to the cause(s) and manner es stated.
2☐ **Medical Examiner:** On the besis of exemination and/or investigation, in my opinion, death occurred at tha tima, date end placa, and due to the cause(s) and manner stated.

29b. Signature and title of cartifier: ▶ Alan Lefkowitz, M.D.
29c. License number: D37035
29d. Date aigned *(Month, Day, Year)*: March 26, 2001

30. Name and eddress of peraon who completed cause of death (Item 23e) (Type, Print): Alan Lefkowitz M.D. 5400 Old Court Rd. Randallstown, Maryland 21133

**State Registrar**

31. Date filed *(Month, Dey, Year)*: MAR 2 7 2001
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

---

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09291

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Leon L. Shipley

2. Date of Death Month: March Day: 25 Year: 2001

3. Time of Death: 0500

4a. Facility Name *(If not institution, give street and number)*: Sinai Hospital of Baltimore

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

**Funeral Director**

5. Social Security Number: 232-26-1276

8. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 29, 1920

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 6620 Sanzo Road

10f. Zip Code: 21209

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- It Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Rece - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+): -0-

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Postal Employee

16b. Kind of Business/Industry: Federal Govt.

17. Father's Name *(First, Middle, Last)*: Charles Shipley

18. Mother's Name *(First, Middle, Maiden Sumame)*: Anna Bumstein

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Betty J. Shipley - Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6620 Sanzo Road; Baltimore, Maryland 21209

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal trom State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Baltimore/Washington Crematory

Date: 3/27/2001

20c. Location - City or Town, Stata: Laurel, MD.

21. Signature of Funeral Service Licensee: Jon L. Hoy. M00869

22. Neme and Address of Fecility: Loring Byers Funeral Directors, Inc. 8728 Liberty Road; Randallstown, Maryland 21133

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.**

Leon Shipley

**Physician /Medical Examiner**

23a. Part I. Ente the diseese, or complicetions that caused the deeth. Do not enter the mode ot dying, such es cardiac or respiratory arrest, shock, or heart tailure. List only one ceuse on eech line.

Approximate Intarval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or es a consequence of):

c.

Due to (or as a consequence ot):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part t.: Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medicel examiner? 1 [ ] Yes 2 [X] No

26. Place ot Deeth *(Check only one)*: Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece ot Injury - At home, tarm, street, tactory, office building, etc. *(Specify)*

28t. Location *(Street and Number or Rural Route Number, City or Town, State)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: This law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and mannar as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: David Kaufman

29c. License number: RES-000

29d. Date signed *(Month, Day, Year)*: March 25, 2001

30. Name and address of person who completed cause ot death (Item 23a) (Type, Print): David Kaufman 2401 West Belvedere Avenue, Baltimore, MD 21215

**State Registrar**

31. Dete filed *(Month, Day, Year)*: MAR 27 2001

32. Registrar's Signeture: Bernard G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09292

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Wayne Smith
2. Date of Death (Month, Day, Year): March 15, 2001
3. Time of Death: 5:30 p.m.
4a. Facility Name (If not institution, give street and number): Stella Maris Hospice
4b. City, Town, or Location of Death: Timonium
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: unknown
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 27 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 31, 1973
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 437 N. Rose St.
10f. Zip Code: 21205
10g. Citizen of What Country? USA

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): unknown; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): COOK
16b. Kind of Business/Industry: Greek Village

17. Father's Name (First, Middle, Last): Wayne Smith Sr.
18. Mother's Name (First, Middle, Maiden Surname): Ann Henderson

19a. Informant's Name/Relationship (Type, Print): Anne Smith - Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3522 Langrehr Rd. Baltimore, Maryland 21244

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion Cemetery
Date: 3/21
20c. Location - City or Town, State: Landsdowne, Maryland

21. Signature of Funeral Service Licensee: Kevin Parker
22. Name and Address of Facility: Kevin A. Parker Funeral Home 3512 Frederick Ave. Baltimore, MD. 21229

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. END STAGE ACQUIRED IMMUNE DEFICIENCY SYNDROME
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D 15504
29d. Date signed (Month, Day, Year): 3.16.01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. EDDIE NAKHUDA 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

**State Registrar**

31. Date filed (Month, Day, Year): MAR 2 7 2001
32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

---

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

MARCH 15, 2001 5:30 p.m.
Baltimore, Maryland 21215-0020

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WAYNE SMITH
Division of Vital Records, P.O. Box 68760,

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09293

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Carol Coldewy Scott | March 24, 2001 | 2:45 am |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Stella Maris Hospice | Timonium | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-36-0862 | 1☐ M 2☒ F | 61 Yrs. | | | Nov 24, 1939 | MD |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Harford | Bel Air | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1111 Hendrix Court | 21014 | United States |

| 11. Marital Status | 12. Was Decedent Ever In U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Clerical | Maryland Racing Commission |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| George Coldewy | Dorothy Reagan |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Dawn Wise /Daughter | 1111 Hendrix Court, Bel Air, MD 21014 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Chesapeake Crematory | Mar 26 2001 | Beltsville, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ M00986 | Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, MD |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. LUNG CANCER WITH BRAIN METASTESIS | |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | b. | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) HOSPICE |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, In my opinion, death occurred et the time, date and place, and due to the cause(s) and mannar stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ | D43725 | 3/24/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR TARIQ MAHMOOD 2300 DULANEY VALLEY Rd. TIMONIUM Md21093

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 2 7 2001 | Geneva G Sparks |

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

MARCH 24, 2001 2:45 AM

CAROL COLDEWY

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar ADMEND ITEM: #1 PER PHY G793 3-27-01 WR.

Reg No. 2001 09294

VICTOR STYLC SR.

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|
| ~~Victor W. Style, Sr.~~ VICTOR W. STYLC SR. | | MARCH 21 2001 | 1:37 PM |
| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death | |
| NORTH ARUNDEL HOSPITAL | GLEN BURNIE | AA COUNTY | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-09-2681 | 1 [X] M 2 [ ] F | 80 Yrs. | | | 2/23/1921 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD. | Anne Arundel | Pasadena | 1 [ ] Yes 2 [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 356 Riverside Dr. | 21122 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1943-1944 | 1 [ ] Yes 2 [X] No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 4 | N/A | Long Shoreman | Steamship Trade Co. |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Stefau Stylc | Marcjaussa Sciorigaj |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Victor Stylc, Jr. (Son) | 356 Riverside Dr. Pasadena MD. 21122 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Glen Haven Mem. Pk. | 3/24/01 | Glen Burnie, MD. |

21. Signature of Funeral Service Licensee: ~~Paul S. Pammel~~

22. Name and Address of Facility: McCully-Polyniak Funeral Home P.A. 3204 Mountain Rd. Pasadena, MD. 21122

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. POSSIBLE ARRHYTHMIA

Due to (or as a consequence of):

c. NIDDM / Hx CARDIAC Thrombus

Due to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 [ ] Yes 2 [X] No 9 [ ] Unknown | 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 [ ] Yes 2 [X] No | 1 [ ] Yes 2 [X] No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 [ ] Yes 2 [X] No | Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] Yes 2 [ ] No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ~~Blakeslee MD~~ | H4A184 | 3/22/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 479 Jumpers Hole Rd Severna Park MD 21146

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 27 2001 | G. Sparks |

DHMH 17 Rev 1/2001

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09295

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: EDWARD SHANNON
2. Date of Death — Month: 3 Day: 21 Year: 01
3. Time of Death: 9:25PM
4a. Facility Name *(If not institution, give street and number)*: BON SECOURS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 213-62-0031
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 47 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Dec 23, 1953
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1615 Parkman Avenue
10f. Zip Code: 21230
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 9 — College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Truck Driver
16b. Kind of Business/Industry: Self-employed

17. Father's Name *(First, Middle, Last)*: Edward Samuel Shannon
18. Mother's Name *(First, Middle, Maiden Surname)*: Eleanora Elizabeth Strauss

19a. Informant's Name/Relationship *(Type, Print)*: Edward S. Shannon (Father)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1615 Parkman Avenue, Baltimore, Maryland 21230

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Bayview Crematory, Inc.
Date: 3/26/2001
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Kevin E Ecker
22. Name and Address of Facility: McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Ave., Balto., Md. 21225-1856

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ASPIRATION PNUEMONIA
Due to (or as a consequence of):
b. ANOXIC ENCEPHALOPATHY
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. DRUG OVERDOSE
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No
26. Place of Death *(Check only one)*: Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Rosita R. Cruz MD
29c. License number: D00303 55
29d. Date signed *(Month, Day, Year)*: march 21, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROSITA R. CRUZ M.D BON SECOURS HOSPITAL

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 27 2001
32. Registrar's Signature: Lenora B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

Amend Item 12 per FHG79404/04/01dhb

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09296

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): FRANK L STOUP
2. Date of Death (Month, Day, Year): MARCH 18 2001
3. Time of Death: 9:12pm
4a. Facility Name (If not institution, give street and number): BALTIMORE VA MEDICAL CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 218 22 5302
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 74 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 24,1926
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Crownsville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 751 Old Herald Harbor Road
10f. Zip Code: 21032
10g. Citizen of What Country?: U.S.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner - Machinist
16b. Kind of Business/Industry: Md. Tool & Die

17. Father's Name (First, Middle, Last): Frank Linwood Stoup Sr.
18. Mother's Name (First, Middle, Maiden Surname): Valley Maude Clary

19a. Informant's Name/Relationship (Type, Print): Janet Stoup / Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 751 Old Herald Harbor Road Crownsville, MD 21032

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MD. State Veteran Cem.
Date: 3/23/01
20c. Location - City or Town, State: Crownsville, Maryland

21. Signature of Funeral Service Licensee: Dana M Zrominowski
22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

**Physician /Medical Examiner**

23a. Part1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. ABDOMINAL AORTIC ANEURYSM RUPTURE

Due to (or as a consequence of):
b. ABDOMINAL AORTIC ANEURYSM

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
PROSTATE CARCINOMA

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Merrill Sparago
29c. License number: P 14658
29d. Date signed (Month, Day, Year): MARCH 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MERRILL SPARAGO, MD 10 N. GREENE ST. BALTIMORE, MD 21201

**State Registrar**

31. Date filed (Month, Day, Year): MAR 26 2001
32. Registrar's Signature: Geneva D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To be completed by the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

218 22 5302

01-1633-510
mnmr
Antoine Smith

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

2001 09297 Reg. No.

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Antoine L. Smith
2. Date of Death Month Day Year: March 23, 2001
3. Time of Death: 5:46 pM
4a. Facility Name (If not institution, give street and number): Shock Trauma Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 215-92-1592
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 25 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 22, 1976
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1647 Thomas Ave.
10f. Zip Code: 21216
10g. Citizen of What Country? USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Afro-American

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Stock Clerk
18b. Kind of Business/Industry: Retail

17. Father's Name (First, Middle, Last): Bruce Turner
18. Mother's Name (First, Middle, Maiden Surname): Karen Smith

19a. Informant's Name/Relationship (Type, Print): Ms. Karen Smith (mother)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2400 Presbury St. Balto. Md. 21216

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Greenmount Crematory
Date: 3/29/2001
20c. Location - City or Town, State: Balto. Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ
22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

**Physician /Medical Examiner**

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Multiple Gunshot Wounds

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [X] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year): 3/23/01
28b. Time of Injury: 1703 pM
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: subject shot
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): street
28f. Location (Street and Number or Rural Route Number, City or Town, State): 1700 Block Thomas Ave. Baltimore, Md

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Dennis J. Cluten
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): March 24, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis Chuten 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): MAR 2 7 2001
32. Registrar's Signature: Lenna B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 09298

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

| | | | | |
|---|---|---|---|---|
| 1. Decedent's Name (First, Middle, Last): Ann Stalnaker | | | 2. Date of Death (Month, Day, Year): March 19 2001 | 3. Time of Death: 3:25 P.M |
| 4a. Facility Name (If not institution, give street and number): 878 Brighton Place | 4b. City, Town, or Location of Death: Glen Burnie | | 4c. County of Death: Anne Arundel | |
| 5. Social Security Number: 268 20 0448 | 8. Sex: 1☐M 2☒F | 7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year): Dec. 21, 1923 |
| 9. Birthplace (State or Foreign Country): Ohio | | | | |

Usual Residence of Decedent

| | | | |
|---|---|---|---|
| 10a. State: Maryland | 10b. County: Anne Arundel | 10c. City, Town or Location: Glen Burnie | 10d. Inside City Limits: 1☐Yes 2☒No |
| 10e. Street and Number: 878 Brighton Place | 10f. Zip Code: 21061 | 10g. Citizen of What Country?: U.S. | |

| | | | |
|---|---|---|---|
| 11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify: | 14. Race - American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th; College (1-4or 5+) | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker | 16b. Kind of Business/Industry: Own Home | |
| 17. Father's Name (First, Middle, Last): Andrew Stas | 18. Mother's Name (First, Middle, Maiden Surname): Mary Zahorancik | | |
| 19a. Informant's Name/Relationship (Type, Print): Kenneth Stalnaker / Husband | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 878 Brighton Place Glen Burnie, Maryland 21061 | | |

| | | | |
|---|---|---|---|
| 20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | 20b. Place of Disposition (Name of cemetery, crematory or other place): Lake View Mem. Park | Date: 3/22/01 | 20c. Location - City or Town, State: Sykesville, Maryland |
| 21. Signature of Funeral Service Licensee: Donna M Zraniewski | 22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 | | |

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Breast Cancer Metastatic — 10 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Alzheimer's Dementia

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| | | |
|---|---|---|
| 29b. Signature and title of certifier: Gary W. Jones MD | 29c. License number: D30111 | 29d. Date signed (Month, Day, Year): March 20, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PO Box 385 Laurel Md 20725-0385

State Registrar

| | |
|---|---|
| 31. Date filed (Month, Day, Year): MAR 2 6 2001 | 32. Registrar's Signature: D. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

ADMEND ITEM: #11 PER INFORMANT G793 3-28-01 WP

# Certificate of Death

Reg. No. 2001 09299

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): DELHI E. THWEATT
2. Date of Death (Month, Day, Year): MARCH 22, 2001
3. Time of Death: 8:45pm
4a. Facility Name (If not institution, give street and number): STELLA MARIS NURSING CENTER HOSPICE
4b. City, Town, or Location of Death: DULANEY VALLEY
4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 156-12-0237
6. Sex: 1☐ M 2☐ F — X
7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 8-14-1920
9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedent

10a. State: MD.
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1905 W. SARATOGA ST.
10f. Zip Code: 21223
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): -12- | College (1-4or 5+): -1-
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): POSTAL WORKER
16b. Kind of Business/Industry: GOVERNMENT

17. Father's Name (First, Middle, Last): JAMES W. THWEATT
18. Mother's Name (First, Middle, Maiden Surname): MARY E. BENNETT

19a. Informant's Name/Relationship (Type, Print): DONALD BARKSDALE(GRANDSON)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1905 W. SARATOGA ST. BALTIMORE, MARYLAND 21223

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ARBUTUS MEMORIAL PARK
Date: 3-27-2001
20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: Jonathan D. Hubner
22. Name and Address of Facility: PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. PROSTATE CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or es e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) HOSPICE

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signature and title of certifier:
29c. License number: D43725
29d. Date signed (Month, Day, Year): 3/23/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

**State Registrar**

31. Date filed (Month, Day, Year): MAR 2 7 2001
32. Registrar's Signature: Emma G Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

MARCH 22, 2001 8:45 p.m.

DELHI THWEATT

**Division of Vital Records, P.O. Box 68760,**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09300

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): CLAUDE MAYFIELD THOMPSON
2. Date of Death: Month March Day 20 Year 2001
3. Time of Death: 2:35am
4a. Facility Name (If not institution, give street and number): St. Agnes Healthcare
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 218-03-5233
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 08-05-1918
9. Birthplace (State or Foreign Country): SC

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 820 N. APPLETON STREET
10f. Zip Code: 21217
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 TH GRADE; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SUPERVISOR
16b. Kind of Business/Industry: PRIVATE

17. Father's Name (First, Middle, Last): ARTHUR WILLIAM THOMPSON
18. Mother's Name (First, Middle, Maiden Surname): PAULINE LOWERY

19a. Informant's Name/Relationship (Type, Print): EARL JUAN THOMPSON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 469 WINTERBERRY DR., EDGEWOOD, MD 21040

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): BALTO. NATIONAL
Date: 03-26-01
20c. Location - City or Town, State: BALTO. MD

21. Signature of Funeral Service Licensee: ▶ Vaughn C
22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL. PIKE, BALTO. MD. 21229

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Hypercarbneic respiratory failure
Due to (or as a consequence of):
b. Cardiac arrest

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Aspiration pneumonia

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ ~~Akakabota~~ medical resident
29c. License number: P-14439
29d. Date signed (Month, Day, Year): March 20, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Bolanle Akakabota, St. Agnes Healthcare, 900 Caton Avenue Baltimore

**State Registrar**

31. Date filed (Month, Day, Year): MAR 27 2001
32. Registrar's Signature: ▶ D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036
Division of Vital Records, P.O. Box 68760,

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

NAME Thompson, Claude

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09301

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Helen Margaret Tucker

2. Date of Death: Month MARCH Day 25 Year 2001

3. Time of Death: 2:58 AM

4a. Facility Name (If not institution, give street and number): ST. AGNES MEDICAL CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

**Funeral Director**

5. Social Security Number: 215-09-2874

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept 7, 1918

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10a. Street and Number: 3310 Benson Ave. #216

10f. Zip Code: 21227

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) — ; College (1-4or 5+) —

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker

16b. Kind of Business/Industry: home

17. Father's Name (First, Middle, Last): John Miller

18. Mother's Name (First, Middle, Maiden Surname): Margaret —

19a. Informant's Name/Relationship (Type, Print): Diane M. Evans

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2606 Crabapple Rd Parkville, Md 21234

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Evans Funeral Chapel-Bel Air

Date: March 25, 2001

20c. Location - City or Town, State: Forest Hill, Maryland

21. Signature of Funeral Service Licensee: ▶ Linda L. Wells

22. Name and Address of Facility: Evans Funeral Chapel 8800 Harford Rd Baltimore, Md 21234

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. PNEUMONIA — 3 DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Nasser Nasseri M.D.

29c. License number: P13600

29d. Data signed (Month, Day, Year): MARCH, 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): NASSER NASSERI M.D. 900 CATON AVE BALTIMORE, MD

**State Registrar**

31. Date filed (Month, Day, Year): MAR 27 2001

32. Registrar's Signature: ▶ D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

NAME TUCKER, HELEN M

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 09302

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|
| Kenneth V Utz | March 21 2001 | 9:45 pm |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 4 Buckley Court | Towson | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-20-1061 | 1☒M 2☐F | 72 Yrs. | | | June 20 1928 | MAryland |

**Usual Residence of Decedent**

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Baltimore | Towson | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 4 Buckley Court | 21286 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8th | | Mechanic | Bowling Alley |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Harvey Utz | Margaret M Sundsburg |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Louise Jones / friend | 4 Buckley Court Towson MD 21286 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Bayview Crematory | 3/24/01 | Baltimore MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ R Terry Connelly | Connelly Funeral Home of Essex 300 Mace Ave. Baltimore MD 21221 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE | >30yrs |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery (Month, Day, Year) |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Squamous Cell Lung Cancer,

23e. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☒Residence 8☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Eric J. Carr | 00053095 | March 23, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eric J. Carr, MD 2360 W. Joppa Rd. #302 Lutherville, Maryland 21093

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 27 2001 | ▶ Geneva G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 09303

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| JOHN HENRY ULRICH, Jr. | March 22, 2001 | 1:00 A.M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 916 E. Belvedere Avenue | Baltimore | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-09-7804 | 1[X] M 2[ ] F | 87 Yrs. | | | Dec. 5, 1913 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | N/A | Baltimore | 1[X] Yes 2[ ] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 916 E. Belvedere Avenue | 21212 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1[ ] Never Married 2[X] Married 3[ ] Widowed 4[ ] Divorced | 1[ ] Yes 2[X] No If Yes, Give Year or Dates: | 1[ ] Yes 2[X] No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 years | | Installer | Telephone |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| John Henry Ulrich, Sr. | Dora Ebersberger |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Margaret Ulrich (wife) | 916 E. Belvedere Ave. Baltimore, Maryland 21212 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1[X] Burial 2[ ] Cremation 3[ ] Removal from State 4[ ] Donation 5[ ] Other (Specify) | Moreland Memorial Park | 3-26-01 | Baltimore, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| George A. Fernane | Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Dysrhythmia-ventricular fibrilation — Immediate

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

b. Arteriosclerotic Heart Disease — years

Due to (or as a consequence of):

c. Hyperlipoprotenemia — years

Due to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1[ ] Yes 2[ ] No 9[ ] Unknown | 23c. If yes, outcome of pregnancy 1[ ] Live birth 2[ ] Fetal death 3[ ] Ectopic pregnancy 4[ ] Pregnant at time of death 5[ ] Other (specify) 9[ ] Unknown | 23d. Date of delivery Month Day Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23e. Did tobacco use contribute to the cause of death? 1[ ] Yes 2[ ] No 3[ ] Probably 4[X] Unknown

| 24a. Was an autopsy performed? 1[ ] Yes 2[X] No | 24b. Were autopsy findings available prior to completion of cause of death? 1[ ] Yes 2[X] No |
|---|---|

| 25. Was case referred to medical examiner? 1[ ] Yes 2[X] No | 26. Place of Death (Check only one) Hospital: 1[ ] Inpatient 2[ ] ER/Outpatient 3[ ] DOA Other: 4[ ] Nursing Home 5[X] Residence 8[ ] Other (Specify) |
|---|---|

| 27. Manner of Death 1[X] Natural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1[ ] Yes 2[ ] No | 28d. Describe how injury occurred |
|---|---|---|---|---|
| | | | | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)

1[X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2[ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Jorge C. Acosta-Torres, MD | D0022633 | 03-23-2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7401 Osler Drive, Ste. 212, Towson, MD 21204

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 27 2001 | G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

---

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2001 093014

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): JANICE R. VECCHIONI
2. Date of Death: Month MARCH Day 24 Year 2001
3. Time of Death: 2020 HRS
4a. Facility Name (If not institution, give street and number): GOOD SAMARITAN HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

**Funeral Director**

5. Social Security Number: 213-34-6533
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 64 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept 19, 1936
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4408 Cook Ave.
10f. Zip Code: 21206
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): —
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker
16b. Kind of Business/Industry: home

17. Father's Name (First, Middle, Last): Rudolf Helmholz
18. Mother's Name (First, Middle, Maiden Surname): Pearl Riccitelli

19a. Informant's Name/Relationship (Type, Print): Paul A. Vecchioni
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4408 Cook Ave. Baltimore, Md 21206

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Redeemer Ceme. Date: March 28, 2001
20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: Krista L Wells
22. Name and Address of Facility: Evans Funeral Chapel 8800 Harford Rd Baltimore, Md 21234

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. PULMONARY HYPERTENSION

Due to (or as a consequence of):
b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. PULMONARY EDEMA

Due to (or as a consequence of):
d. SEPSIS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
ACUTE RENAL FAILURE

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: RESIDENT PHYSICIAN
29c. License number: P13450
29d. Date signed (Month, Day, Year): MARCH 24, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KOFI A. APPIAH M.D., GOOD SAMARITAN HOSPITAL, BALTIMORE

**State Registrar**

31. Date filed (Month, Day, Year): MAR 27 2001
32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09305

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): LENA WILLIAMS
2. Date of Death (Month, Day, Year): MARCH 24 2001
3. Time of Death: 6:30 AM
4a. Facility Name (If not institution, give street and number): RUXTON PIKESVILLE NURSING HOME
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 215-05-1199
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 94 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): OCT. 2, 1906
9. Birthplace (State or Foreign Country): MD

Usual Residance of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1015 SCOTTS HILL DRIVE
10f. Zip Coda: 21208
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Raca - American Indien, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired): CLERICAL
16b. Kind of Business/Industry: INTERNAL REVENUE

17. Father's Name (First, Middle, Last): SAMUEL LEVIN
18. Mother's Name (First, Middle, Maidan Surname): ROSE BERMAN

19a. Informant's Name/Relationship (Type, Print): MRS. LEAH LEVIN/SISTER-IN-LAW
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1015 SCOTTS HILL DR. BALTIMORE, MD 21208

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Othar (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): BETH TFILOH CONG.
Date: 3/25/01
20c. Location - City or Town, Stata: WOODLAWN, MD

21. Signature of Funeral Service Licensee: ▶ Edward C. Rund
22. Name end Address of Facility: SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that causad tha daath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | ACUTE CEREBROVASCULAR ACCIDENT | 1 HOUR |
| Due to (or as a consequenca of): b. | GENERALIZED ARTERIOSCLEROSIS | 20 YEARS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disaase or injury that initiated avants resulting in death) Last — Due to (or as a consequence of): c. | | |
| Due to (or as a consequence of): d. | | |

Part ii. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Part i.

- DEMENTIA
- HISTORY OF PNEUMONIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Wara autopsy findings availeble prior to completion of cause of death? 1☐ Yas 2☐ No

25. Was case refarrad to madical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Othar: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Placa of Injury - At home, farm, straet, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To tha best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of axamination and/or invastigation, in my opinion, death occurred at tha tima, data and place, and dua to tha cause(s) and manner stated.

29b. Signature end title of certifier: ▶ L. Leiby M.D.
29c. License number: D-22609
29d. Date signed (Month, Day, Year): MARCH 24, 2001

30. Nama and address of person who completed cause of daath (Item 23a) (Type, Print): RUBEN REIDER M.D. 7445 FURNACE BRANCH RD GLEN BURNIE MD 21060

**State Registrar**

31. Date filed (Month, Day, Year): MAR 27 2001
32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

---

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 09306

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| Minnie Whitfield | | | 3 / 22 / 2001 | 7 :13 A.M |
| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death | | |
| 3006 N. Hilton Street | Baltimore | N/A | | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 138-14-8273 | 1☐M 2☒F XX | 103 Yrs. | | | 3 26 1897 | Va |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md | N/A | Baltimore | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3006 N. Hilton Street | 21216 | U S A |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 6th grade | N/A | Domestic Worker | Private Homes |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Mack Walton | Lizzie Booker |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Minnie E. Josey- Granddaughter | 3006 N. Hilton Street Baltimore, Md 21216 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | New Bethel Church | 3/28/2001 | Meherrin, Va |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Gabrielle Cook | March F/H West 4300 Wabash Avenue Baltimore, Md 21215 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. ALZHEIMER'S DEMENTIA | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnent at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one)

Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Osei Wusu MD | D24089 | 03/22/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ACHAN OSEI-WUSU MD 5710 WABASH AVE. BALTIMORE MD 21215

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 27 2001 | Jessica G. Sparks |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified as soon as possible.**

Division of Vital Records, P.O. Box 68760,

To the Medical/Certifying Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09307

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: MAJOR WATKINS SR.

2. Date of Death Month Day Year: MARCH 23, 2001

3. Time of Death: 10:00am

4a. Facility Name *(If not Institution, give street and number)*: 1155 N. CARROLLTON AVENUE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: NA

**Funeral Director**

5. Social Security Number: 229-14-8384

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: APR. 15, 1914

9. Birthplace *(State or Foreign Country)*: VA

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1307 WINCHESTER STREET

10f. Zip Code: 21217

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1944-1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* AFRICAN AMERICAN

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 5th; College (1-4or 5+): NA

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: MECHANIC HELPER

16b. Kind of Business/Industry: CONSTRUCTION

17. Father's Name *(First, Middle, Last)*: SAMUEL WATKINS

18. Mother's Name *(First, Middle, Maiden Surname)*: JOSEPHINE BEASLEY

19a. Informant's Name/Relationship *(Type, Print)*: CAROLINE W. YOUNGBLOOD (DAUGHTER)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1155 N. CARROLLTON AVE. BALTIMORE, MD 21217

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: GARRISON FOREST VET. CEM

Date: 3/29/01

20c. Location - City or Town, State: OWINGS MILLS, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: WYLIE FUNERAL HOME PA 638 N. GILMOR STREET BALTIMORE, MD 21217

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Metastatic colon cancer — 4 mo.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☑ Other (Specify) Hospice

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John W. Payne, MD

29c. License number: D13012

29d. Date signed *(Month, Day, Year)*: 3/23/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John Payne, MD 6565 N. Charles St 21204

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 27 2001

32. Registrar's Signature: [signature] B Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**To be Completed by Funeral Director**

Submit: Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

3/23/01 10 AM

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Major Watkins Sr.

20

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 09308

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Beatrice Ann Wood
2. Date of Death (Month, Day, Year): March 24, 2001
3. Time of Death: 12:40 P. M
4a. Facility Name (If not institution, give street and number): Gilchrist Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore Co.

**Funeral Director**

5. Social Security Number: 219-18-5377
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 77 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): January 17, 1924
9. Birthplace (State or Foreign Country): Wilmington, DE.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore Co.
10c. City, Town or Location: Parkville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8800 Walther Blvd. unit#4417
10f. Zip Code: 21234
10g. Citizen of What Country? United States of America

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Home Maker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Clarence Lee Walker, Jr.
18. Mother's Name (First, Middle, Maiden Surname): Helen Hannah Collins

19a. Informant's Name/Relationship (Type, Print): Mr. Robert Bruce Wood, Sr. (Husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8800 Walther Blvd. Unit#4417 Parkville, Maryland 21234

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Service Corporation
Date: 3/26/2001
20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: Jeffrey L. Gair, Sr. ▶ Jeffrey L. Gair, Sr
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. OVARIAN CANCER — Approximate Interval: 3 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ W. Anthony Riley, MD
29c. License number: D25205
29d. Date signed (Month, Day, Year): March 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W. A. Riley MD 6701 N. Charles St. Balto. Md 21204

**State Registrar**

31. Date filed (Month, Day, Year): MAR 27 2001
32. Registrar's Signature: ▶ Gene G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified as soon as possible.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Beatrice Wood 3/24/01 12:40pm

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09309

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Kenneth James Warren
2. Date of Death — Month: March Day: 25th Year: 2001
3. Time of Death: 4:00P
4a. Facility Name *(If not institution, give street and number)*: North Arundel Hospital
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 217-26-2520
6. Sex: 1☒M 2☐F
7. Age *(In yrs. last birthday)*: 50 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 2-27-1951
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒Yes 2☐No

10a. Street and Number: 206 S.Clinton Street
10f. Zip Code: 21224
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Painter
16b. Kind of Business/Industry: Painter

17. Father's Name *(First, Middle, Last)*: Kenneth Warren
18. Mother's Name *(First, Middle, Meiden Surneme)*: Rose Eggers

19a. Informant's Name/Relationship *(Type, Print)*: wife Deborah A. Warren
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 206 s. Clinton St., Baltimore, Md. 21224

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Greenmount crematory — Date: 3/28/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Maria M. Zannino
22. Name and Address of Facility: Joseph N. Zannino Jr. Funeral Hm. 263 S. Conkling St., Baltimore, Maryland 21224

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0020**

Warren.

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Alcoholic Cirrhosis, hepatitis B and C infection

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Division of Vital Records, P.O. Box 68760,**

Kenmark

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature], MD
29c. License number: D48006
29d. Date signed *(Month, Day, Year)*: 3-25-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KOFI OWUSU-BOAITEY. MD 301 HOSPITAL DR. GLENBURNIE, MD 21061

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 27 2001
32. Registrar's Signature: ▶ D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09310

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ETHEL V WILMER
2. Date of Death (Month, Day, Year): MARCH 24 2001
3. Time of Death: 5:45PM
4a. Facility Name (If not institution, give street and number): THE GOOD SAMARITAN HOSPITAL OF MD
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 215-05-4802
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 27, 1907
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: ☒ Yes 2☐ No
10e. Street and Number: 3939 Roland Avenue Apt. 304
10f. Zip Code: 21211
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed ☒ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes ☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Hostess
16b. Kind of Business/Industry: Oriole Cafeteria

17. Father's Name (First, Middle, Last): Harry Brown
18. Mother's Name (First, Middle, Meiden Surname): Margaret Musgrove

19a. Informant's Name/Relationship (Type, Print): Rita M. Penn Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4210 Edgehill Avenue Baltimore, MD 21211

20a. Method of Disposition: ☒ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, crematory or other placa): Parkwood Cemetery
Date: 3/28/01
20c. Location - City or Town, Stete: Parkville, MD

21. Signeture of Funeral Service Licensee: Tracy L Carpenter
22. Name end Address of Facility: Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, MD 21211

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Causa (Finel disease or condition resulting in death) a. | SEPSIS | TWO DAYS |
| Due to (or as a consequence of): | | |
| b. | URINARY TRACT INFECTION | ONE WEEK |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c. | | |
| Due to (or as a consequence of): d. | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably ☒ Unknown

24a. Was an autopsy performed? 1☐ Yes ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes ☒ No

25. Was case referred to medical examiner? 1☐ Yes ☒ No
26. Place of Death (Check only one): Hospital: ☒ 1 Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: ☒ 1 Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): ☒ 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Qinglin Gao, MD
29c. License number: P14417
29d. Date signed (Month, Day, Year): MARCH 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): QINGLIN GAO, MD 5601 LOCH RAVEN BOULEVARD, BALTIMORE MD 21239-2295

**State Registrar**

31. Date filed (Month, Day, Year): MAR 27 2001
32. Registrar's Signature: Barbara G Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

01-1556-005
CJ
Ray White

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM#1,23a,27,28a-f per ME G795 050601 SS

# Certificate of Death

Reg. No. 2001 09311

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Ray P White III | March 20 2001 | 08:31 A.M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 510 Riverside Drive | Essex | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 219-96-5952 | 1☒M 2☐F | 31 Yrs. | | | Sept.28,1969 | MAryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Baltimore | Middle River | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of Whel Country? |
|---|---|---|
| 1313 Gunpowder Crossing Lane | 21220 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12th | | Printer | Cavanaugh Printing |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Ray P White Jr. | April L MArch |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Lisa White / sister | 322 Nicholson Road Baltimore MD 21221 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Oak LAwn Cemetery | 3/23/01 | Baltimore MD |

21. Signature of Funeral Service Licensee ▶ R. Terry Connelly

22. Name and Address of Facility: Connelly Funeral Home of Essex, 300 Mace Ave. Baltimore MD 21221

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. NARCOTIC INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown | 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | 23d. Date of delivery Month / Day / Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☒Yes 2☐No | 1☒Yes 2☐No |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

25. Was case referred to medical examiner? 1☒Yes 2☐No

28. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 8☒Other (Specify)

27. Manner of Death: 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☒Could not be determined

| 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| found: 3-20-01 | found: 8:20 A M | 1☐Yes 2☒No | unknown |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| house | 510 Riverside Dr., Essex, MD |

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ J. M. Tie for | O.C.M.E. | March 21, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner, M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 27 2001 | ▶ Jennie B. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

01-1601-510
crn
Eugene Wright

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar ADMEND ITEM: #23 PART I, 27 PER MEO G794 4-5-01 WR: *Certificate of Death*

2001 09312
Reg. No.

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Eugene Wright | March 22 2001 | 10:01 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Sinai Hospital | Baltimore | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-70-6978 | 1☒M 2☐F | 42 Yrs. | | | July 4, 1958 | Md. |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md | N/A | Baltimore | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 4311 Pimlico Road | 21215 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 10th grade | N/A | Unemployed | Unemployed |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Oscar Wright | Erestine Murray |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Clinton Wright (Brother) | 6217 Pilgrim Rd. Balto. Md. 21214 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Vochelle Cem. | 3/27/2001 | Baltimore, Md. |

21. Signature of Funeral Service Licensee ▶ Funeral Counselor

22. Name and Address of Facility: Betts Funeral Home, 1129 N. Caroline Balto. Md. 21213

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☒Yes 2☐No | 1☒Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☒Yes 2☐No | Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] M.D. | O.C.M.E. | March 23, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARY G. RIPPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 27 2001 | ▶ [signature] |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification; To Be Completed by Physician/Medical Examiner**

DHMH 17 Rev 1/2001

ORIGINAL

01-1579-510
crn
Trena Webster

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM 23a,ptII,27 per ME G795 051701 SS

# Certificate of Death

2001 09313 Reg. No.

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| TRENA WEBSTER | | | March | 21 | 2001 | 12:00 PM |
| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | | 4c. County of Death | | | |
| 2601 Madison Avenue, Apartment 812 | Baltimore | | N/A | | | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year Months | Days | If Under 24 Hrs. Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 213-84-1360 | 1☐M 2☒F | 33 Yrs. | | | | | 6-6-1967 | MD |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | | BALTIMORE | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2601 MADISON AVE | 21217 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Yeer or Detes: | 1☐Yes 2☒No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | UNKNOWN | UNKNOWN |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Meiden Sumame) |
|---|---|
| ALONZO WEBSTER | LANICE HARRIS |

| 19a. Informent's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) |
|---|---|
| JACQUELINE MORTON | 3502 MILLEVALE RD BALTIMORE MD 21244 |

| 20a. Method of Disposition | 20b. Piece of Disposition (Name of cemetery, cremetory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Buriel 2☐Cremetion 3☐Removal from State 4☐Donation 5☐Other (Specify) | ST. THOMAS CEM. | 3/27/2001 | RANDALLSTOWN MD |

| 21. Signature of Funerel Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶E.N. WALKER JR | ESTEP BROS FUNERAL SERVICE P.A. 1300 EUTAW PLACE BALTIMORE MD 21217 |

**Physician /Medical Examiner**

23a. Part I. Enter the diseesa, or complications that caused the death. Do not enter the mode ot dying, such as cerdiec or respiratory arrest, shock, or heert failure. List only one ceuse on each line.

| | | Approximeta Interval Between Onset and Death |
|---|---|---|
| Immediete Cause (Final diseese or condition resulting in death) | a. CONCENTRIC LEFT VENTRICULAR HYPERTROPHY | |
| Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Last | Due to (or es e consequence of): | |
| | b. Due to (or as a consequence of): | |
| | c. Due to (or es a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the pest 12 months? 1☐Yes 2☐No 9☐Unknown | 23c. If yes, outcome of pregnency 1☐Live birth 2☐Fetel deeth 3☐Ectopic pregnancy 4☐Pregnant at time ot death 5☐Other (specify) 9☐Unknown | 23d. Date of delivery Month Day Year |
|---|---|---|

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

MORBID OBESITY

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☒Yes 2☐No | 1☒Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☒Yes 2☐No | Hospitel: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 8☒Other (Specify) at scene |

| 27. Manner of Death | 28a. Dete of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury et Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | | 1☐Yes 2☐No | |
| | 28e. Place of Injury - At home, tarm, street, fectory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rurel Route Number, City or Town, State) |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated.
2☒ **Medical Examinar:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner stated.

| 29b. Signature end title of certifier | 29c. License number | 29d. Dete signed (Month, Day, Yeer) |
|---|---|---|
| ▶ Theodore McKay MD | O.C.M.E. | March 22, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
THEODORE McKAY 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 27 2001 | ▶ Brenda G. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

*Certificate of Death*

Reg. No. 2001 09314

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| James | Oliver | Wolf | March 23, 2001 | 3:15 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 8406 Cove Road | Dundalk | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-30-3255 | 1 X M 2 F | 67 Yrs. | | | May 1, 1933 | Md. |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md. | Baltimore | Dundalk | 1 Yes 2 X No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 8406 Cove Road | 21222 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 Never Married 2 X Married 3 Widowed 4 Divorced | 1 X Yes 2 No If Yes, Give Year or Dates: | 1 Yes 2 X No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 yrs. | | Roller | Steel |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Edward A wolf Sr. | Mary A. Kelly |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Patricia A. Wolf wife | 8406 Cove Road, Dundalk, MD. 21222 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | Garrison Forrest | Mar. 26, 2001 | Owings Mills, Md. |

21. Signature of Funeral Service Licensee: John E Connelly Jr

22. Name and Address of Facility: Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Rd. Dundalk, Md. 21222

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Multiple Myeloma | 11 Months |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 Yes 2 No 9 Unknown | 1 Live birth 2 Fetel death 3 Ectopic pregnancy 4 Pregnent at time of death 5 Other (specify) 9 Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 Yes 2 X No | 1 Yes 2 X No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 Yes 2 X No | Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA | Other: 4 Nursing Home 5 X Residence 8 Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | M | 1 Yes 2 No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Janet Cooper MD | D46118 | March 26, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JANET COOPER MD 1447 YORK Rd Lutherville MD 21093

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 27 2001 | Bernard G Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09315

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Mary N. Ward
2. Date of Death — Month: March Day: 20 Year: 2001
3. Time of Death: 7:45 P.
4a. Facility Name (If not institution, give street and number): Deer's Head Center
4b. City, Town, or Location of Death: Salisbury
4c. County of Death: Wicomico

**Funeral Director**

5. Social Security Number: 577-30-5837
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 74 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 17 1926
9. Birthplace (State or Foreign Country): Louisiana

Usual Residence of Decedent

10a. State: Md.
10b. County: Worcester
10c. City, Town or Location: Berlin
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 11544 S. Dolly Circle
10f. Zip Code: 21811
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates: X
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No — Specify:
14. Race - American Indian, Black, White, etc. — Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 — College (1-4 or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Home Owner

17. Father's Name (First, Middle, Last): Otho Williams
18. Mother's Name (First, Middle, Maiden Surname): Nell Jarzo

19a. Informant's Name/Relationship (Type, Print): Bonnie Boulanger (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11544 S. Dolly Circle, Berlin, Md. 21811

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Glen Haven Memorial Park — Date: 3/24/2001
20c. Location - City or Town, State: Glen Burnie, Md.

21. Signature of Funeral Service Licensee: Jamie Arthurs
22. Name and Address of Facility: McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Md. 21122

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Stage IV Adenocarcinoma with metastasis — 3 months
Due to (or as a consequence of):
b. Primary site unknown
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Congestive heart Failure
Unstable angina and left ventricular dysfunction

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M. Shrestha, M.D
29c. License number: D0016278
29d. Date signed (Month, Day, Year): March 21st 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DEER'S HEAD CENTER, P.O. Box 2018 SALISBURY, Md 21802-2018

**State Registrar**

31. Date filed (Month, Day, Year): MAR 27 2001
32. Registrar's Signature: Bruce G. Sparks

DHMH 16 Rev 6/95

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09316

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): William West
2. Data of Death Month Day Year: MARCH 10, 2001
3. Time of Death: 12:40 PM
4a. Facility Name (If not institution, give street and number): MARYLAND GENERAL HOSPITAL
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 238-20-3300
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 14, 1922
9. Birthplace (State or Foreign Country): unk.

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1501 N. DuKeland St.
10f. Zip Code: 21216
10g. Citizen of What Country? USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unemployed
16b. Kind of Business/Industry: N/A

17. Father's Name (First, Middle, Last): unk
18. Mother's Name (First, Middle, Maiden Surname): unk.

19a. Informent's Name/Relationship (Type, Print): Ms. Janie Turman
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): unk.

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion
Date: 3/29/2001
20c. Location - City or Town, State: Lansdowne, Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ
22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediete Cause (Final diseese or condition resulting in death):
a. HYPERTENSION, SCHZOPHRENIA
Due to (or as a consequence of):
b. DEMENTIA
Due to (or es e consequence of):
c. RENAL INSUFFICIENCY
Due to (or as e consequence of):
d.

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes en autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Panding investigetion 6 [ ] Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29e. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, and due to the cause(s) and mannar as stated. 2 [ ] **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, dete and place, and due to tha cause(s) and menner steted.

29b. Signature and title of certifier: Badika
29c. License number: 89367
29d. Date signed (Month, Dey, Year): MARCH 10, 2001

30. Nema and address of person who completed cause of death (Item 23a) (Type, Print): NDOFUNSU BADIKA M.D. C/O MARYLANDGENERAL HOSPITAL

**State Registrar**

31. Date filed (Month, Day, Year): MAR 27 2001
32. Registrer's Signeture: Geneva G Sparks

ORIGINAL

DHMH 16 Rev 6/95

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28d show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

**To Be Completed by Funeral Director**

William West

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09317

GREGORY ALLEN

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): GREGORY ALLEN
2. Date of Death: Month MARCH Day 13 Year 2001
3. Time of Death: 9:27 PM
4a. Facility Name (If not institution, give street and number): CIVISTA MEDICAL CENTER
4b. City, Town, or Location of Death: LAPLATA
4c. County of Death: CHARLES

**Funeral Director**

5. Social Security Number: 317-82-4290
6. Sex: [X] M [ ] F
7. Age (In yrs. last birthday): 39 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): SEPT. 28, 1961
9. Birthplace (State or Foreign Country): INDIANA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: CHARLES
10c. City, Town or Location: LA PLATA
10d. Inside City Limits: [ ] Yes [X] No
10e. Street and Number: 7915 CRAIN HIGHWAY
10f. Zip Code: 20646
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: [ ] Never Married [X] Married [ ] Widowed [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? [X] Yes [ ] No If Yes, Give Year or Dates: 1983-1995
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): [ ] Yes [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH GRADE; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CHEF
16b. Kind of Business/Industry: FOOD SERVICE

17. Father's Name (First, Middle, Last): HENRY CLAY ALLEN
18. Mother's Name (First, Middle, Maiden Surname): VIVIAN BERNICE HOWARD ALLEN

19a. Informant's Name/Relationship (Type, Print): SARAH ANN ALLEN / WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7915 CRAIN HIGHWAY, LA PLATA, MARYLAND 20646

20a. Method of Disposition: [X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CROWN HILL CEMETERY
Date: 3/21/01
20c. Location - City or Town, State: INDIANAPOLIS, INDIANA

21. Signature of Funeral Service Licensee: Lydia C. Thornton Johnson
LYDIA C. THORNTON JOHNSON M00583
22. Name and Address of Facility: THORNTON FUNERAL HOME, P.A.
3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CARDIAC ARREST — MINUTES

Due to (or as a consequence of):
b. ACUTE MYOCARDIAL INFARCTION — 1-2 HOURS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. CORONARY ARTERY DISEASE — 10 YEARS

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
HYPERTENSION, HYPERLIPIDEMIA, ATHEROSCLEROTIC VASCULAR DISEASE, FAMILY HISTORY OF CORONARY DISEASE, TOBACCO ABUSE, ALCOHOL ABUSE

23b. Did tobacco use contribute to the cause of death? [ ] Yes [ ] No [ ] Probably [ ] Unknown

24a. Was an autopsy performed? [ ] Yes [ ] No
24b. Were autopsy findings available prior to completion of cause of death? [ ] Yes [ ] No

25. Was case referred to medical examiner? [ ] Yes [X] No
26. Place of Death (Check only one): Hospital: [ ] Inpatient [X] ER/Outpatient [ ] DOA; Other: [ ] Nursing Home [ ] Residence [ ] Other (Specify)

27. Manner of Death: [X] Natural [ ] Accident [ ] Suicide [ ] Homicide [ ] Pending investigation [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? [ ] Yes [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: G. Srinivasan
29c. License number: D-46345
29d. Date signed (Month, Day, Year): 3/14/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GOPALAKRISHNAN SRINIVASAN M.D. 3600 LEONARDTOWN RD WALDORF MD 20601

**State Registrar**

31. Date filed (Month, Day, Year): MAR 16 2001
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as soon as possible.

To Be Completed by Funeral Director

GREGORY ALLEN

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 09318

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Evelyn Young Ambrose
2. Date of Death (Month, Day, Year): March 10, 2001
3. Time of Death: 1:05 PM
4a. Facility Name *(If not institution, give street and number)*: Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

**Funeral Director**

5. Social Security Number: 214-10-5759
8. Sex: 1☐M 2☒F
7. Age *(In yrs. last birthday)*: 90 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 10-2-1910
9. Birthplace *(State or Foreign Country)*: Maryland

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 1608 Rock Creek Drive
10f. Zip Code: 21702
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12); College (1-4or 5+): 2 years
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Bookkeeper
18b. Kind of Business/Industry: Music/Jewelry Store

17. Father's Name *(First, Middle, Last)*: Millard Sigler Young
18. Mother's Name *(First, Middle, Maiden Surname)*: Rebecca Karn

19a. Informant's Name/Relationship *(Type, Print)*: Mr. M. Timothy Ambrose (Son)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6939 Deer Spring Lane Middletown, Md. 21769

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Smithsburg Crematory
Date: 3/11/01
20c. Location - City or Town, State: SMithsburg, Md.

21. Signature of Funeral Service Licensee: Robert E Dailey Jr
22. Name and Address of Facility: ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 N. Market St. Frederick, Md. 21701

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. MASSIVE STROKE — Approximate Interval Between Onset and Death: 2 HOURS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other *(specify)* _____ 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: HYPERTENSION

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 8☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D47611
29d. Date signed *(Month, Day, Year)*: MARCH 10, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): NEIL WARAMBCAN MD 1475 TANEY AVE #204 FREDERICK MD 21702

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 12 2001
32. Registrar's Signature: Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 09319

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Samuel Atran

2. Date of Death Month Day Year: March 12, 2001

3. Time of Death: 8:40 A.M.

4a. Facility Name *(If not institution, give street and number)*: Hebrew Home of Greater Washington

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 200-10-3606

6. Sex: 1☐M 2☐F — X

7. Age *(In yrs. last birthday)*: 89 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec. 10, 1911

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 6105 Montrose Road

10f. Zip Code: 20852

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 Years; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Salesman

16b. Kind of Business/Industry: Insurance

17. Father's Name *(First, Middle, Last)*: Abraham Atran

18. Mother's Name *(First, Middle, Maiden Surname)*: Minnie

19a. Informant's Name/Relationship *(Type, Print)*: Rita Gaylin - Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4617 Norwood Drive, Chevy Chase, Maryland 20815

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Montefiore Cemetery

Date: 3/14/2001

20c. Location - City or Town, State: Jenkintown, PA.

21. Signature of Funeral Service Licensee: Donald C. Stottlemyer

22. Name and Address of Facility: DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CVA — 2 WEEKS

Due to (or as a consequence of):

b. HYPERTENSIVE CEREBROVASCULAR DISEASE — YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. ESSENTIAL HYPERTENSION — YEARS

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

RESTRICTIVE LUNG DISEASE

CONGESTIVE HEART FAILURE

23b. **Did tobacco use contribute to the cause of death?** 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☒Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Steven Lipson MD

29c. License number: D 05885

29d. Date signed *(Month, Day, Year)*: 03/12/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): STEVEN LIPSON 6121 MONTROSE ROAD, ROCKVILLE, MD

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 19 2001

32. Registrar's Signature: Bruce B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28c-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09320

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): HOWARD H. ASKINS
2. Date of Death (Month, Day, Year): MARCH 13, 2001
3. Time of Death: 1:50 AM
4a. Facility Name (If not Institution, give street and number): Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: MONTGOMERY

**Funeral Director**

5. Social Security Number: 200-10-2192
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 84 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 9, 1917
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 2308 Kansas Avenue
10f. Zip Code: 20910
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6th — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mill worker
16b. Kind of Business/Industry: T.W. Parry Co.

17. Father's Name (First, Middle, Last): Unknown
18. Mother's Name (First, Middle, Meiden Surname): Susie Askins

19a. Informant's Name/Relationship (Type, Print): Harold A. Askins (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1122 Meurilee Lane, Silver Spring, MD 20901

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Ash Memorial Cem.
Date: 3/20/01
20c. Location - City or Town, State: Sandy Spring, MD

21. Signature of Funeral Service Licensee: George L. Snowden
22. Name and Address of Facility: SNOWDEN FUNERAL HOME, P.A. 246 N. Wash. St., Rockville, MD 20850

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Multilobar pneumonia | 2 days |
| Due to (or as a consequence of): b. | Urinary tract infection | 1 day |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c. | Myocardial infarction | 1 day |
| Due to (or as a consequence of): d. | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: R Anderson, MD
29c. License number: D52381
29d. Date signed (Month, Day, Year): 3/13/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Robyn Anderson 1238 Central Avenue #606 Bowie MD 20721

**State Registrar**

31. Date filed (Month, Day, Year): MAR 15 2001
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09321

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): CONSTANCE ROSE AMERICA

2. Date of Death: Month MARCH Day 13 Year 2001

3. Time of Death: 2003

4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: Not Applicable

**Funeral Director**

5. Social Security Number: 219-68-7419

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 44 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 23, 1956

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Gaithersburg

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 15473 Peachleaf Drive

10f. Zip Code: 20878

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): –

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Waitress

16b. Kind of Business/Industry: Restaurant

17. Father's Name (First, Middle, Last): Francis J. Rose

18. Mother's Name (First, Middle, Maiden Surname): Ruth M. Sweitzer

19a. Informant's Name/Relationship (Type, Print): Keith J. Rose/ Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15473 Peachleaf Drive, Gaithersburg, MD 20878

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc.

Date: March 15, 2001

20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: [signature] MD0689

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. HYPOTENSION — 3 DAYS

Due to (or as a consequence of):

b. CARDIOMYOPATHY — 1 YEAR

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

PULMONARY EMBOLISM

PLEURAL EFFUSIONS

URINARY TRACT INFECTION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: RES-000

29d. Date signed (Month, Day, Year): MARCH 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GREGORY ANG, 600 N WOLFE STREET, BALTIMORE, MD 21287

**State Registrar**

31. Date filed (Month, Day, Year): MAR 16 2001

32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 6

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09322

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Kathleen M. Bennett
2. Date of Death (Month, Day, Year): March 8, 2001
3. Time of Death: 300am
4a. Facility Name (If not institution, give street and number): Sligo Creek Nursing & Rehab
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 255-14-1715
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov 19, 1911
9. Birthplace (State or Foreign Country): SC

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Kensington
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 11218 Midvale Rd.
10f. Zip Code: 20895
10g. Citizen of What Country?: United States

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): John Montgomery
18. Mother's Name (First, Middle, Maiden Surname): Birdie Genoble

19a. Informant's Name/Relationship (Type, Print): Sylvia Didone /Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11218 Midvale Rd., Kensington, MD 20895

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Westover Memorial Park | Date: Mar 12 2001
20c. Location - City or Town, State: Augusta, GA

21. Signature of Funeral Service Licensee: ▶ Beverly L. Hallette
22. Name and Address of Facility: Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, MD

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Aspiration Pneumonia — 2 weeks
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Alzheimer's Disease

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Phillip W. Poth, M.O.
29c. Licensa number: D22309
29d. Date signed (Month, Day, Year): March 8th, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Phillip W. Poth, M.O., 9013 Flower Avenue, Silver Spring, MD. 20901

**State Registrar**

31. Date filed (Month, Day, Year): MAR 13 2001
32. Registrar's Signature: ▶ Bruce G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09323

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Khyena Buslovich

2. Date of Death: Month March Day 12 Year 2001

3. Time of Death: 7:00 Am

4a. Facility Name (If not institution, give street and number): The Hebrew Home of Greater Washington

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 217-92-8381

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): December 27, 1908

9. Birthplace (State or Foreign Country): Russia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 6121 Montrose Road

10f. Zip Code: 20852

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Chemist

16b. Kind of Business/Industry: Engineering

17. Father's Name (First, Middle, Last): Yakov Lazarvich Buslovich

18. Mother's Name (First, Middle, Maiden Surname): Bluma Shapiro

19a. Informant's Name/Retelionship (Type, Print): Natalie Kramer/Grandaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 544 Azalea Drive, Rockville, MD 20850

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Geo. Wash. University Medical Center

Date: March 12 2001

20c. Location - City or Town, State: Washington, D.C.

21. Signature of Funeral Service Licensee: Shuta Gindin

22. Name and Address of Facility: Columbia Mortuary Services, Inc. P.O. Box 58007 Washington, D.C.

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. acute cardio - pulmonary arrest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary artery disease

Due to (or as a consequence of):

c. Sepsis

Due to (or as a consequence of):

d. gangrenous right foot

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic cerebral ischemia

osteoporosis Cholilethiasis

anemia Constipation

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Consuelo Alvarez

29c. License number: D: 44907

29d. Date signed (Month, Day, Year): March 12th, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CONSUELO ALVAREZ 6105 Montrose Road Rockville, MD 20852

**State Registrar**

31. Date filed (Month, Day, Year): MAR 16 2001

32. Registrar's Signature: Bruce G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Buslovich Khyena

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09324

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Richard Albert Burgo
2. Date of Death (Month, Day, Year): March 12, 2001
3. Time of Death: 725am
4a. Facility Name (If not institution, give street and number): Collingswood Nursing & Rehabilation
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 182-14-7643
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Apr 7, 1918
9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 4110 Heathfield Rd.
10f. Zip Code: 20853
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1941-45
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Railroad Fireman
16b. Kind of Business/Industry: Railroad

17. Father's Name (First, Middle, Last): Leopold Burgo
18. Mother's Name (First, Middle, Maiden Surname): Rosanna (UNK)

19a. Informant's Name/Relationship (Type, Print): Anne Dunlap /Social Worker
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 401 Hungerford Dr, Rockville, MD 20850

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory
Date: Mar 14 2001
20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: ▶ Beverly L. Hallette
22. Name and Address of Facility: Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, MD

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia
Due to (or as a consequence of):
b. Dysphagia
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Cerebrovascular Accident
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ K R Lillie MD
29c. License number: D53244
29d. Date signed (Month, Day, Year): March 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Katharine R. Lillie, MD 11140 Rockville Pike, PMB 348, Rockville, MD 20852

**State Registrar**

31. Date filed (Month, Day, Year): MAR 13 2001
32. Registrar's Signature: ▶ G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036
Division of Vital Records, P.O. Box 68760,

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Burgo

1 of 1

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09325

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Marguerite L. Brown

2. Date of Death (Month, Day, Year): March 11, 2001

3. Time of Death: 1:30 am

4a. Facility Name (If not institution, give street and number): Charlestown Care Center

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 239-03-8262

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): August 8, 1908

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Greenbelt

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 8L Plateau

10f. Zip Code: 20770

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

16b. Kind of Business/Industry: America Enka Corp.

17. Father's Name (First, Middle, Last): Charles Nelson Lominac

18. Mother's Name (First, Middle, Maiden Surname): Bertha McQuillen

19a. Informant's Name/Relationship (Type, Print): Beverly B. Hawkins - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 20418 Waters Point Lane Germantown, Maryland 20874

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Riverside Cemetery | Date: 3/16/2001

20c. Location - City or Town, State: Asheville, North Carolina

21. Signature of Funeral Service Licensee: ▶ Matthew A Brown

22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): a. End Stage Dementia — Year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or es a consequence of):

c. Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: ▶ Julian Salazar MD

29c. License number: D 51051

29d. Date signed (Month, Day, Year): March 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Andres Salazar 711 Maiden Choice Lane, Catonsville, MD, 21228

**State Registrar**

31. Date filed (Month, Day, Year): MAR 14 2001

32. Registrar's Signature: ▶ Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

Name: Marguerite Brown

10

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 09326

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: HELEN B. BROWN

2. Date of Death Month Day Year: MARCH 9, 2001

3. Time of Death: 3:40 AM

4a. Facility Name *(If not institution, give street and number)*: HEARTLAND HEALTH CARE CENTER

4b. City, Town, or Location of Death: ADELPHI

4c. County of Death: PRINCE GEORGES

**Funeral Director**

5. Social Security Number: 219-36-8750

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: FEB. 3, 1913

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MD.

10b. County: PRINCE GEORGES

10c. City, Town or Location: COLLEGE PARK

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 5001 PIERCE AVE.

10f. Zip Code: 20740

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: NURSE

16b. Kind of Business/Industry: UNIVERSITY OF MD. CAMPUS COLLEGE PK.

17. Father's Name *(First, Middle, Last)*: BENJAMIN BRISCOE

18. Mother's Name *(First, Middle, Maiden Surname)*: ELLEN LOMAX

19a. Informant's Name/Relationship *(Type, Print)*: SHIRLEY BROWN/NIECE

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5107 UPSHUR ST., BLADENSBURG, MD. 20710

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MARYLAND VETERANS CEM.

Date: 3/15/01

20c. Location - City or Town, State: CHELTENHAM, MD.

21. Signature of Funeral Service Licensee: W. W. Chambers MOOO91

22. Name and Address of Facility: CHAMBERS FUNERAL HOMES, P.A., 5801 CLEVELAND AVE. RIVERDALE, MD. 20737

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE CONGESTIVE HEART FAILURE — MONTH

Due to (or as a consequence of):

b. CHRONIC AORTIC STENOSIS — YRS.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC RENAL INSUFFICIENCY, CHRONIC OBSTRUCTIVE LUNG DISEASE

SEVERE GENERALIZED ATHEROSCLEROSIS

CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: R Rustagi MD

29c. License number: D24720

29d. Date signed *(Month, Day, Year)*: MARCH 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAVINDERK RUSTAGI, M.D. 6132 LANDOVER RD., CHEVERLY, MD. 20785

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 12 2001

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09327

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): FRANK BROULIK
2. Date of Death: Month MARCH Day 10 Year 2001
3. Time of Death: 1335
4a. Facility Name (If not institution, give street and number): 3207 WOODBINE STREET
4b. City, Town, or Location of Death: CHEVY CHASE
4c. County of Death: MONTGOMERY

**Funeral Director**

5. Social Security Number: 473-44-5421
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 83 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): October 2, 1917
9. Birthplace (State or Foreign Country): Minnesota

Usual Residance of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Chevy Chase
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 3207 Woodbine Street
10f. Zip Code: 20815
10g. Citizen of Whet Country?: United States

11. Maritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1936-1976
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elemantary/Secondary (0-12): - ; College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired): Captain
16b. Kind of Business/Industry: United States Navy

17. Fether's Name (First, Middle, Last): Jacob Broulik
18. Mother's Name (First, Middle, Maidan Surneme): Agnes Unger

19a. Informant's Name/Relationship (Type, Print): Franta J. Broulik/ Daughter
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code): 170 N. Union Street, Lambertville, NJ 08530-1625

20a. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Montgomery Crematorium, Inc.
Date: March 12, 2001
20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: M00689
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediete Cause (Final disease or condition resulting in death): a. CARCINOMA OF BLADDER

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in daath) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and mannar as stated. 2☒ **Medical Examiner**: On tha basis of axamination and/or investigation, in my opinion, death occurred at the tima, data and place, and due to the cause(s) end menner stated.

29b. Signature and title of certifier: (MD)
29c. License number: D15236
29d. Date signed (Month, Dey, Year): MARCH 10, 2001

30. Name end eddrass of person who completed causa of death (Item 23a) (Type, Print): CARL I. MARGOLIS, MD 11125 ROCKVILLE PIKE, ROCKVILLE, MD 20852

**State Registrar**

31. Date filed (Month, Dey, Yeer): MAR 12 2001
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

---

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.** 6

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

25+1

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED ITEM#10a-f per fh G799 092801 ss

# Certificate of Death

Reg. No. 2001 09328

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Emma N. Brehm | March 13, 2001 | 437pm M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 11604 Summer Oak Dr. | Germantown | Montgomery |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 451-05-9353 | 1☐ M 2☒ F | 92 Yrs. | | | Sep 30, 1908 | NC |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| ~~MD~~ New Jersey | ~~Montgomery~~ Morris | ~~Germantown~~ Boonton | 1☒ Yes 2☐ ~~No~~ |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| ~~11604 Summer Oak Dr.~~ 11 River Road | ~~20874~~ 07005 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 5+ | Teacher | Education |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| James Anderson Nelson | Winnie Blakeney |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Vicki Patino /Daughter | 11604 Summer Oak Dr., Germantown, MD 20874 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetary, cramatory or other pleca) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Chesapeake Crematory | Mar 15 2001 | Beltsville, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Style D Lohmann | Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, MD |

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

6 Baltimore, Maryland 21215-0036

**Physician /Medical Examiner**

23a. Part I. Enter the diseasa, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on eech line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Causa (Final disease or condition resulting in death) | a. Cerebrovascular Accident | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequenca of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequance of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Data of delivary |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of daath 5☐ Other (specify) _____ 9☐ Unknown | Month Day Year |

Part II. Othar significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

| 23e. Did tobecco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown | 1☐ Yes 2☒ No | 1☐ Yes 2☒ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Othar (Specify) |

| 27. Manner of Death | 28a. Data of Injury (Month, Day Year) | 28b. Tima of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |
| | 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) | | | 28f. Location (Street and Numbar or Rural Route Number, City or Town, State) |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Brehm

10

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, data and place, and due to tha cause(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of examination and/or invastigation, in my opinion, daath occurred at the time, date and place, and due to tha cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ KR Lillie MD | D53244 | March 14, 2001 |

30. Name and address of person who completed cause of daath (Item 23a) (Typa, Print)
Katharine R. Lillie, MD 11140 Rockville Pike, PMB 348, Rockville, MD 20852

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 16 2001 | ▶ B. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09329

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Frederick W. Brandt
2. Date of Death (Month, Day, Year): March 8, 2001
3. Time of Death: 2:10P.
4a. Facility Name *(If not institution, give street and number)*: 2212 Hermitage Avenue
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 147-03-0117
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 87 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June22,1913
9. Birthplace *(State or Foreign Country)*: New Jersey

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 2212 Hermitage Avenue
10f. Zip Code: 20902
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Reca - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highast grada completed)*: Elementery/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work dona during most of working life. DO NOT use retired)*: Contractor
16b. Kind of Bualness/Industry: self employed

17. Father's Neme *(First, Middle, Last)*: Robert Brandt
18. Mother's Neme *(First, Middle, Maiden Surneme)*: Elizabeth Nunne

19a. Informent's Neme/Relationship *(Type, Print)*: Joan E. Haver - Daughter
19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: same as #10a - 10g

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Ramoval from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Nema of cemetery, cremetory or other piece)*: Metropolitan Crematory — Dete: 3/8/2001
20c. Location - City or Town, Stata: Alexandria, Virginia

21. Signeture of Funerel Service Licensee: ▶ Matthew A Brown
22. Name and Address of Fecility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Road Beltsville, Md. 20705

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complicetions thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line. — Approximete Interval Between Onset and Death

Immediete Cause (Final diseese or condition resulting in deeth)
a. Chronic obstructive pulmonary disease
Due to (or as a consequence of):
b. Asbestosis
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avants resulting in deeth) Last
Dua to (or es a consequence of):
c. Aortic stenosis
Dua to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were eutopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical exeminer? 1 [ ] Yes 2 [X] No

28. Plece of Death *(Check only one)*: Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Othar *(Specify)*

27. Menner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Dete of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28a. Placa of Injury - At home, farm, straat, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, dete end plece, and due to the cause(s) and menner as stated. 2 [ ] **Medical Examiner**: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted.

29b. Signeture end title of certifier: ▶ L. Bahadori
29c. License number: D47928
29d. Deta signed *(Month, Dey, Year)*: March 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Lila Bahadori, M.D. 10301 Georgia Avenue, #304 Silver Spring, Maryland 20902

**State Registrar**

31. Data filed *(Month, Day, Year)*: MAR 14 2001
32. Registrar's Signeture: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0036

Frederick Brandt. GF

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit copy.

Division of Vital Records, P.O. Box 68760,

6

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09330

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Diana Mae Barker
2. Date of Death (Month, Day, Year): March 12 2001
3. Time of Death: 2033
4a. Facility Name (If not institution, give street and number): Civista Medical Center
4b. City, Town, or Location of Death: La Plata
4c. County of Death: Charles

**Funeral Director**

5. Social Security Number: 220-46-6333
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 52 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Apr. 30, 1948
9. Birthplace (State or Foreign Country): Maryland

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD
10b. County: St. Mary's
10c. City, Town or Location: Mechanicsville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 29675 Allison Circle
10f. Zip Code: 20659
10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: At Home

17. Father's Name (First, Middle, Last): Louis C. Perell
18. Mother's Name (First, Middle, Maiden Surname): Eva Rubin

19a. Informant's Name/Relationship (Type, Print): Husband William John Barker, Jr.
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 29675 Allison Circle Mechanicsville, MD 20659

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Charles Mem. Grdns.
Date: March 17, 2001
20c. Location - City or Town, State: Leonardtown, MD

21. Signature of Funeral Service Licensee: Joseph [illegible]
22. Name and Address of Facility: Brinsfield-Echols Funeral Home, P.A. 30195 Three Notch Rd, Charlotte Hall, MD

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. asthma | minutes |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
severe, persistent asthma
nasal polyps

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☑ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Jonathan Fears
29c. License number: A39522
29d. Date signed (Month, Day, Year): 3/13/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): 110 Hospital Rd. Dr. Frederick, MD 20701 Jonathan Fears, MD

**State Registrar**

31. Date filed (Month, Day, Year): MAR 16 2001
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09331

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Robert Paul Boyle

2. Date of Death (Month, Day, Year): March 11, 2001

3. Time of Death: 2:40 A.M.

4a. Facility Name (If not institution, give street and number): Casey House Montgomery Hospice

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 577-28-2747

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 9, 1921

9. Birthplace (State or Foreign Country): Washington, D.C.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Bethesda

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6009 Southport Drive

10f. Zip Code: 20814

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): -

College (1-4or 5+): 1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Construction Foreman

16b. Kind of Business/Industry: Telephone Company

17. Father's Name (First, Middle, Last): Daniel A. Boyle

18. Mother's Name (First, Middle, Maiden Surname): Elva Marie Nelson

19a. Informant's Name/Relationship (Type, Print): Elsie M. Boyle/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6009 Southport Drive, Bethesda, Maryland 20814

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc.

Date: March 13, 2001

20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: [signature] 00689

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular Accident — days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. — Due to (or as a consequence of):

c. — Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Cerebrovascular Arteriosclerosis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D 15046

29d. Date signed (Month, Day, Year): March 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen J. Newman, M.D. 19261 Montgomery Village Ave., Montgomery Village, MD 20886

**State Registrar**

31. Date filed (Month, Day, Year): MAR 12 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

20

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09332

**Physician /Medical Examiner**

1. Decedent's Neme *(First, Middle, Last)*: Mabel Alice Bonsall
2. Dete of Deeth Month / Dey / Yeer: March 8, 2001
3. Time of Death: 3 pm
4a. Facility Neme *(If not Institution, give street end number)*: Westminster Nursing & Rehab.
4b. City, Town, or Location of Deeth: Eldersburg
4c. County of Deeth: Carroll

**Funeral Director**

5. Sociel Security Number: 290-10-5264
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. lest birthdey)*: 91 Yrs. — If Under 1 Yeer: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Yeer)*: Dec 17, 1909
9. Birthpiece *(State or Foreign Country)*: OH

Usuel Residence of Decedent

10a. Stete: MD
10b. County: Carroll
10c. City, Town or Location: Sykesville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2810 Kaywood Place
10f. Zip Code: 21784
10g. Citizen of What Country?: United States
11. Meritel Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Rece - Americen Indien, Bleck, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home
17. Father's Neme *(First, Middle, Last)*: Frederick Gilcrest
18. Mother's Neme *(First, Middle, Meiden Surneme)*: Louise Bailey
19a. Informent's Neme/Reletionship *(Type, Print)*: Thomas Bonsall /Son
19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 230 Stoney Run Lane, Baltimore, MD 21201
20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Plece of Disposition *(Neme of cemetery, cremetory or other place)*: Chesapeake Crematory — Dete: Mar 12 2001
20c. Location - City or Town, Stete: Beltsville, MD
21. Signeture of Funerel Servica Licensee: ▶ [signature] M00784
22. Neme end Address of Feciliity: Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, MD

**Physician /Medical Examiner**

23a. Pert I. Enter the disease, or complicetions that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one ceuse on eech line. — Approximete Interval Between Onset end Death

Immediete Cause (Finel diseese or condition resulting in death): e. CVA — 2mos
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last:
b. ASCVD — 25yr
Due to (or es e consequence of):
c.
Due to (or es e consequenca of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No
26. Plece of Deeth *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 8☐ Other *(Specify)*
27. Menner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined
28a. Dete of Injury *(Month, Dey Yeer)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rurel Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete and plece, and due to the cause(s) and menner es stated. 2☐ **Medical Examiner:** On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, dete and plece, and due to the cause(s) and menner stated.

29b. Signeture and title of certifier: ▶ [signature]
29c. License number: D25443
29d. Dete signed *(Month, Dey, Yeer)*: 3-9-2001
30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Tomw. Middleton 4288 Pook Rd, Westminster, Md 21157

**State Registrar**

31. Dete filed *(Month, Dey, Yeer)*: MAR 13 2001
32. Registrer's Signeture: ▶ [signature] D. Sparks

DHMH 16 Rev 6/95

---

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 09333

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Charlie J. Black | March 9, 2001 | 6:28 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Holy Cross Hospital | Silver Spring | Montgomery |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 417-38-8827 | 1 [X] M 2 [ ] F | 66 Yrs. | | | April 19, 1934 | Alabama |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| N/A | N/A | Washington, D.C. | 1 [X] Yes 2 [ ] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 6435 13th Street, N.W. | 20012 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: | 1 [ ] Yes 2 [X] No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 5+ | Educator | Education |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Napoleon Black | Mattie Stallworth |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Lola Pearl Black/Wife | 6435 13th Street, N.W. Wash., D.C. 20012 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Rock Creek Cemetery | 03/16/01 | Washington, D.C. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Joanna L. Ellsberry | McGuire Funeral Service, Inc. 7400 Georgia Ave., N.W. Wash., D.C. 20012 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Chronic obstructive Pulmonary disease | years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 [ ] Yes 2 [ ] No 9 [ ] Unknown | 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown | 1 [ ] Yes 2 [X] No | 1 [ ] Yes 2 [ ] No |

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) | |
|---|---|---|
| 1 [ ] Yes 2 [X] No | Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] Yes 2 [ ] No | |

| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Amendhiralta MD | D38262 | March 9, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr Mandhiralta 2401 Research BLVD Suite 240 Rockville MD 20850

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 14 2001 | ▶ Brenda G. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

GF

10

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09334

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): JACOB BERMAN
2. Date of Death (Month, Day, Year): MARCH 7, 2001
3. Time of Death: 11:10PM
4a. Facility Name (If not institution, give street and number): SUBURBAN HOSPITAL
4b. City, Town, or Location of Death: BETHESDA
4c. County of Death: MONTGOMERY

**Funeral Director**

5. Social Security Number: 022-18-4182
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): FEB. 20, 1918
9. Birthplace (State or Foreign Country): NEW YORK

Usual Residence of Decedent

10a. State: NEW YORK
10b. County: BROOME
10c. City, Town or Location: VESTAL
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10a. Street and Number: 606B CLUB HOUSE ROAD
10f. Zip Code: 13850
10g. Citizen of What Country? UNITED STATES

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PRESIDENT
16b. Kind of Business/Industry: TRUCKING COMPANY

17. Father's Name (First, Middle, Last): ISAAC BERMAN
18. Mother's Name (First, Middle, Maiden Surname): SARAH SMALL

19a. Informant's Name/Relationship (Type, Print): EDWARD S. BERMAN / SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9310 WILDOAK DRIVE, BETHESDA, MD 20814

20e. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GARDEN OF REMEMBRANCE
Date: 03/09/01
20c. Location - City or Town, State: CLARKSBURG, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: DANZANSKY GOLDBERG MEMORIAL CHAPEL 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications thel caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Causa (Final diseasa or condition resulting in death) | a. NON-HODGKIN'S LYMPHOMA | 4 MONTHS |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | b. | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or es e consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: SPINAL CORD COMPRESSION WITH PARESIS.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No
26. Place of Death (Check only one): Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D23308
29d. Date signed (Month, Day, Year): MARCH 8, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): VICTOR M. PRIEGO, MD 6410 ROCKLEDGE DR. #625 BETHESDA, MD 20817

**State Registrar**

31. Date filed (Month, Day, Year): MAR 13 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0020**

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Berman Jacob 3/7/01 @ 11:10PM

12

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09335

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Esther Berlowe
2. Date of Death (Month, Day, Year): March 10, 2001
3. Time of Death: 2:45 PM
4e. Facility Name (If not institution, give street and number): Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 158-07-9794
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 27, 1913
9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Potomac
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 11832 Goya Drive
10f. Zip Code: 20854
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): - ; College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Director
16b. Kind of Business/Industry: Nursing Home

17. Father's Name (First, Middle, Last): Pincus Moskowitz
18. Mother's Name (First, Middle, Maiden Surname): Frieda Kalfus

19a. Informant's Name/Relationship (Type, Print): Jonathan A. Maizel/ Grandson
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11832 Goya Drive, Potomac, Maryland 20854

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc.
Date: March 13, 2001
20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature] M00689
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Finat disease or condition resulting in death) a. | Pneumonia | 1 week |
| Due to (or as a consequence of): b. | Chronic Obstructive pulmonary disease | Years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c. | | |
| Due to (or as a consequence of): d. | | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Atrial Fibrillation; Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: ▶ [signature], M.D.
29c. License number: D 50283
29d. Date signed (Month, Day, Year): 3/11/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DINA DARWISH 2501 Porter Street, NW Washington, D.C. 20018

**State Registrar**

31. Date filed (Month, Day, Year): MAR 13 2001
32. Registrar's Signature: ▶ [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0020**

**Division of Vital Records, P.O. Box 68760,**

Berlow, Esther 3/10/01 2:45pm

20

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09336

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): John L. Bennett, Jr.

2. Date of Death (Month, Day, Year): March 14, 2001

3. Time of Death: 4:00PM

4a. Facility Name (If not institution, give street and number): Hebrew Home

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 181-14-4192

6. Sex: 1☒M 2☐F

7. Age (in yrs. last birthday): 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 20, 1922

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Bethesda

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 5622 Newington Court

10f. Zip Code: 20816

10g. Citizen of What Country?: United States

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Yeer or Dates: World War II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondery (0-12):

College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Engineer

16b. Kind of Business/Industry: Private Engineering

17. Father's Name (First, Middle, Last): John Loux Bennett

18. Mother's Name (First, Middle, Maiden Surname): Clarissa Texter

19a. Informant's Name/Relationship (Type, Print): Elizabeth F. Bennett/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5622 Newington Court, Bethesda, Maryland 20816

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other pleca): Montgomery Crematorium, Inc.

Date: March 16, 2001

20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: M00689

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave. Bethesda, Maryland 20814-3501

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. SEPSIS — 1 WEEK

Due to (or as a consequence of): b. ASPIRATION PNEUMONIA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequenca of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

30+1

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D.

29c. License number: D18084

29d. Date signed (Month, Day, Year): MARCH 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): D-D. PATEL M.D. 6121 MONTROSE RD, ROCKVILLE, MD 20852

**State Registrar**

31. Date filed (Month, Day, Year): MAR 16 2001

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 09337

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Edward M. Bellucci, Sr.

2. Date of Death (Month, Day, Year): March 10, 2001

3. Time of Death: 8:07 PM

4a. Facility Name *(If not institution, give street and number)*: Suburban Hospital Pavilion

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 041-12-6690

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 9, 1919

9. Birthplace *(State or Foreign Country)*: Connecticut

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Potomac

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 8705 Bells Mill Road

10f. Zip Code: 20854

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No. If Yes, Give Year or Dates: World War II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+): –

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Secretary/Treasurer

16b. Kind of Business/Industry: Bricklayer's Union

17. Father's Name *(First, Middle, Last)*: Michael G. Bellucci

18. Mother's Name *(First, Middle, Maiden Surname)*: Armida Cinquini

19a. Informant's Name/Relationship *(Type, Print)*: Bernice C. Bellucci/ Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8705 Bells Mill Road, Potomac, Maryland 20854

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery

Date: March 16, 2001

20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: M00689

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

**Baltimore, Maryland 21215-0020**

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ATHEROSCLEROTIC CARDIO VASCULAR DISEASE — 4 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: RENAL FAILURE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: P. Talwar, M.D.

29c. License number: D36552

29d. Date signed *(Month, Day, Year)*: MARCH 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): P. TALWAR, 50 W. Edmonston Drive #401. Rockville MD. 20852

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Division of Vital Records, P.O. Box 68760,**

BELLUCCI, EDWARD

24+1

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 13 2001

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09338

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Marion G. Beckwith
2. Date of Death (Month, Day, Year): March 14, 2001
3. Time of Death: 10:03 pm
4a. Facility Name (If not institution, give street and number): Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 219-12-5838
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 94 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 1, 1906
9. Birthplace (State or Foreign Country): Connecticut

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 216 Granville Drive
10f. Zip Code: 20901
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Assistant Director of Curriculum
16b. Kind of Business/Industry: Board of Education

17. Father's Name (First, Middle, Last): Patrick F. Casey
18. Mother's Name (First, Middle, Maiden Surname): Bridget M. O'Leary

19a. Informant's Name/Relationship (Type, Print): W. Doris Poole/ Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 216 Granville Drive, Silver Spring, MD 20901

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery
Date: Mar 17 2001
20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: ▶ William L Byrd
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Perforated Sigmoid Diverticulitis — 28 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Adenocarcinoma Sigmoid Colon

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Ira Tannebaum MD
29c. License number: D 20772
29d. Date signed (Month, Day, Year): March 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ira Tannebaum, MD 1145 19th Street NW , #313 Washington, DC 20036

**State Registrar**

31. Date filed (Month, Day, Year): MAR 16 2001
32. Registrar's Signature: ▶ Brenda B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09339

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Cleo Miller Beard
2. Date of Death (Month, Day, Year): March 7, 2001
3. Time of Death: 7:45PM
4a. Facility Name (If not institution, give street and number): Sunrise
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 400-40-6099
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 23, 1923
9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 8 Baltimore Road
10f. Zip Code: 20850
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Bieck, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): / College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Registered Nurse
16b. Kind of Business/Industry: Nursing
17. Father's Name (First, Middle, Last): Earl Raymond Andre
18. Mother's Neme (First, Middle, Meiden Sumeme): Jessie Ruth May
19a. Informent's Neme/Reletionship (Type, Print): Gene Petersen-Beard/Stepson
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 11307 Cloverhill Drive, Silver Spring, MD 20902
20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donation 5☐ Other (Specify)
20b. Ptece of Disposition (Name of cemetery, cremetory or other piece): Haven Hill Cemetery
Dete: Mar. 10 2001
20c. Location - City or Town, Stete: Columbia, Kentucky
21. Signature of Funerel Service Licensee: Daniel E. Perry M00803
22. Name and Address of Feclity: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave. Bethesda, Maryland 20814-3501

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complicetions thet ceused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heert feilure. List only one ceuse on eech line. (Approximete Interval Between Onset and Deeth)

Immediete Cause (Finel disease or condition resulting in deeth)
a. Hypertension — Years
Due to (or as a consequence of):
b. Hypothyroid — Years

Sequentially list conditions, if any, leading to Immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last
Due to (or as e consequence of):
c. Osteoporosis — Years
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physicien**: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of exemination and/or investigation, in my opinion, deeth occurred et the time, dete and place, and due to the cause(s) end manner steted.

29b. Signature and title of certifier: S Rao MD
29c. License number: D35792
29d. Date signed (Month, Day, Year): March 8, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Swaroop G. Rao, M.D. 50 West Edmonston Drive, #504, Rockville, Maryland 20852

**State Registrar**

31. Date filed (Month, Day, Year): MAR 12 2001
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

12

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09340

Ball, Margaret 3-6-01 @ 1630 Dr. Ramanan med rec'd #41467 2

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Margaret Ball

2. Date of Death (Month, Day, Year): March 6, 2001

3. Time of Death: 4:30 PM

4a. Facility Name (If not institution, give street and number): Southern Maryland Hospital

4b. City, Town, or Location of Death: Clinton

4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 231-38-6686

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 26, 1928

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Temple Hills

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 5502 Mansfield Drive

10f. Zip Code: 20748

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Domestic

16b. Kind of Business/Industry: Housework

17. Father's Name (First, Middle, Last): Harrison Spencer

18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Leckins

19a. Informant's Name/Relationship (Type, Print): Dorothy King -Cousin

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 606 East Cerritos St., Rialto, CA 92376

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Orrick Cemetery

Date: 3/12/01

20c. Location - City or Town, State: Winchester, VA

21. Signature of Funeral Service Licensee: Karen L. Woodall

22. Name and Address of Facility: Metropolitan Funeral Service, Inc. 5517 Vine Street, Alexandria, VA 22310

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. DILATED CARDIOMYOPATHY

Due to (or as a consequence of):

b. CORONARY ARTERY DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ATRIAL FIBRILLATION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D53885

29d. Date signed (Month, Day, Year): 3/7/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): VENKAT. S. RAMANAN 7501 SUITLAND ROAD #307 CLINTON MD 20735.

**State Registrar**

31. Date filed (Month, Day, Year): MAR 12 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 09341

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Sara F. Cutis | March 11 2001 | 9:52a M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Montgomery General Hospital | Olney | Montgomery |

**Funeral Director**

| 5. Social Security Number | 8. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 413-50-8181 | 1☐M 2☒F | 67 Yrs. | | | March 30,1933 | Tennessee |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Montgomery | Gaithersburg | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 9008 Kimblehunt Drive | 20882 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Henry G. Howard | Sarah E. Rogers |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Donna Kyle/ Daughter | 9008 Kimblehunt Drive, Gaithersburg, Maryland 20882 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Data | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Forest Hills Cemetery | 3/15/2001 | Chattanooga,Tennessee |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Todd O Wyman | Olin L. Molesworth P. A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction — Immediate

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ____ Due to (or as a consequence of):

c. ____ Due to (or as a consequence of):

d. ____

IF FEMALE:
23b. Was decedent pregnant in tha past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) ____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pneumonia

History of Stroke with hemiparesis,expressive aphasia

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case relerred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one) — Hospital: 1☐Inpatient 2☐ER/Outpatient 3☒DOA — Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☒Certifying Phyaicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2☐Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| P Henjum MD | D35045 | March 11, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Philip G. Henjum M.D. 3416 Olandwood Court, Olney, Maryland 20832 #204

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 12 2001 | Geneva G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification; To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09342

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): EVELYN LORRAINE COOKSEY
2. Date of Death: Month March Day 15 Year 2001
3. Time of Death: 1:20AM
4a. Facility Name (If not institution, give street and number): Charles County Nursing Rehab Center
4b. City, Town, or Location of Death: La Plata
4c. County of Death: Charles

**Funeral Director**

5. Social Security Number: 216-40-8311
8. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 86 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): October 21, 1914
9. Birthplace (State or Foreign Country): SC

Usual Residence of Decedent

10a. State: MD
10b. County: Charles
10c. City, Town or Location: La Plata
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 10200 La Plata Road
10f. Zip Code: 20646
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): James William Anderson
18. Mother's Name (First, Middle, Meidan Sumame): Ethel Lula Jones Anderson

19a. Informant's Neme/Relationship (Type, Print): Donald Cooksey, Sr./Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code): 23245 Esperanza Dr. LexingtonPark, MD 20653

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cematary, crematory or othar place): Mt. Rest Cemetery
Date: 3/17/01
20c. Location - City or Town, Stete: La Plata, MD.

21. Signature of Funeral Service Licensee: ▶ David C. Echols M00945
22. Name and Address of Facility: AREHART-ECHOLS FUNERAL HOME, P.A. P.O. BOX 567 LA PLATA, MD. 20646

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heert failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediete Cause (Final disease or condition resulting in death)
a. CONGESTIVE HEART FAILURE

Due to (or es a consequenca of):
b. DILATED CARDIOMYOPATHY

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Lest
Due to (or as e consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings aveilable prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and pleca, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or Investigetion, in my opinion, deeth occurred et the time, dete and piece, and due to the cause(s) end manner stated.

29b. Signeture and title of certifier: ▶ MD
29c. License number: D53885
29d. Date signed (Month, Day, Yaar): 3/15/2001

30. Neme and address of person who completed cause of death (Item 23e) (Type, Print): VENKAT. S. RAMANAN 6 POST OFFICE ROAD #101 WALDORF MD 20602

**State Registrar**

31. Date filed (Month, Day, Year): MAR 16 2001
32. Registrar's Signature: ▶ G. Sparks

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

DHMH 16 Rev 6/95

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09343

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Thomas J. Curran
2. Date of Death Month Day Year: March 9, 2001
3. Time of Death: 7:55 am
4a. Facility Name (If not institution, give street and number): 3014 Homewood Parkway
4b. City, Town, or Location of Death: Kensington
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 578-05-3942
8. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 83 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Mar. 27, 1917
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Kensington
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3014 Homewood Parkway
10f. Zip Code: 20895
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Coordinator Meetings and Exhibits
16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): Thomas John Curran
18. Mother's Neme (First, Middle, Maiden Surnema): Gertrude Dohoney

19a. Informant's Name/Relationship (Type, Print): Barbara T. Curran (wife)
19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 3014 Homewood Parkway Kensingotn,Maryland 20895

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Gate of Heaven Cemetery
Date: 3/12/01
20c. Location - City or Town, State: Silver Spring,Maryland

21. Signature of Funeral Service Licensee: ▶ J. Keir Stile
22. Nama and Addrass of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd.,W.,Silver Spring,MD 20901

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onsat and Death

Immediate Cause (Final disease or condition resulting in death)
a. Chronic Obstructive Lung Disease — Years

Due to (or as a consequence of):
b. Congestive Hear Failure — Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last
Due to (or as a consequence of):
c. Coronary Artery Disease — Years

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings availeble prior to completion of ceuse of death? 1☐ Yas 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Rasidence 6☐ Other (Specify)

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the tima, deta end place, and due to tha causa(s) and manner as stated. 2☐ **Medicaf Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and mannar stated.

29b. Signature and title of certifier: ▶ G. Nicholas Rogentine, Jr. M.D.
29c. License number: D 22854
29d. Data signed (Month, Day, Year): March 9,2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): G. Nicholas Rogentine, Jr., M.D. 10180 Connecticut Avenue Kensington,MD 20895

**State Registrar**

31. Date filed (Month, Day, Year): MAR 12 2001
32. Registrer's Signature: ▶ Brenda G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attanding Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 09344

Physician /Medical Examiner

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| RICHARD | JAMES | CAMPBELL | March 12, 2001 | 0805 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| PENINSULA REGIONAL MEDICAL CENTER | SALISBURY | WICOMICO |

Funeral Director

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 296-68-8042 | 1 [X] M 2 [ ] F | 40 Yrs. | | | August 8, 1960 | Ohio |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Worcester | Berlin | 1 [ ] Yes 2 [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 21 Seabreeze Road | 21811 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: Navy 1980 | 1 [ ] Yes 2 [X] No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | - | Self Employed | Handy Man |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Richard Allen Campbell | Faythe Carol Mass |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Sue Campbell/Sister | 6738 South 1800 East, Ogden, Utah 84405 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Salisbury Crematory | 3/13/01 | Salisbury, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ David A. Thompson M01051 | Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 |

To Be Completed by Funeral Director

Richard Campbell

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23e or 28e-i show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Myocardial Infarction | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): Renal Failure | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 [ ] Yes 2 [ ] No 9 [ ] Unknown | 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown | 1 [ ] Yes 2 [X] No | 1 [ ] Yes 2 [ ] No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 [ ] Yes 2 [X] No | Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] Yes 2 [ ] No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

29a. Certifier (Check only one) 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Benjamin Meyer | D 30743 | 3/12/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Benjamin Meyer 400 Eastern Shore Drive, Salisbury MD 21804

2+ VA DQ

State Registrar

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 13 2001 | ▶ Donna G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Amend #4a., 3/14/2001, GF, Montg.Co.

## Certificate of Death

Reg. No. 2001 09345

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Carmen Cruz

2. Date of Death: Month 03 Day 11 Year 2001

3. Time of Death: 0945

4a. Facility Name (If not institution, give street and number): SMMC St. Mary's Nursing Home

4b. City, Town, or Location of Death: Leonardtown

4c. County of Death: ST MARYS.

**Funeral Director**

5. Social Security Number: 547-87-0469

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): October 8, 1930

9. Birthplace (State or Foreign Country): Philippines

Usual Residence of Decedent

10a. State: Maryland

10b. County: Charles

10c. City, Town or Location: Waldorf

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2288 Community Drive

10f. Zip Code: 20601

10g. Citizen of What Country? Philippines

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Filipino

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Food Service

16b. Kind of Business/Industry: Cafeteria

17. Father's Name (First, Middle, Last): Francisco Macalino

18. Mother's Name (First, Middle, Maiden Surname): Maria Castro

19a. Informant's Name/Relationship (Type, Print): Edgar Cruz/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2288 Community Drive, Waldorf, MD 20601

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Fairfax Memorial Park

Date: 3/14/01

20c. Location - City or Town, State: Fairfax, VA

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Murphy Falls Church Funeral Home 1102 W. Broad St., Falls Church, VA 22046

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Carcinomatosis — months

Due to (or as a consequence of):
b. Cancer of Colon — yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4■ Unknown

24a. Was an autopsy performed? 1☐ Yes 2■ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2■ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4■ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1■ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1■ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ James P. Jarboe M.D

29c. License number: D 06419

29d. Date signed (Month, Day, Year): 3-11-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James P. Jarboe, M.D. 24035 Three Notch Rd., Hollywood, MD 20636

**State Registrar**

31. Date filed (Month, Day, Year): MAR 14 2001

32. Registrar's Signature: ▶ Barbara B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09346

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ELIZABETH R. COSTOLO
2. Date of Death (Month, Day, Year): MARCH 13, 2001
3. Time of Death: 12:45 AM
4a. Facility Name (If not institution, give street and number): BROOKE GROVE NURSING & REHABILITATION CENTER
4b. City, Town, or Location of Death: SANDY SPRING
4c. County of Death: MONTGOMERY

**Funeral Director**

5. Social Security Number: 187-01-8994
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 95 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan 22, 1906
9. Birthplace (State or Foreign Country): Pennsylvania

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Olney
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 19621 Charline Manor Road
10f. Zip Code: 20832
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: Church

17. Father's Name (First, Middle, Last): Conrad Rossmann
18. Mother's Name (First, Middle, Maiden Surname): Henrietta Grimm

19a. Informant's Name/Relationship (Type, Print): Yetta Churilla, Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 19621 Charline Manor Road, Olney, MD 20832

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Mt. Lebanon Cemetery
Date: Mar 16 2001
20c. Location - City or Town, State: Pittsburgh, PA

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: DeVol Funeral Home, 10 E. Deer Park Drive, Gaithersburg, MD 20877

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Finat disease or condition resulting in death) a. | Hypoxemia | 2 wks |
| Due to (or as a consequenca of): b. | Lung mass | 2 years |
| Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest — Due to (or as e consequence of): c. | | |
| Due to (or as a consequence of): d. | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Rectal carcinoma

HTN

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 8☐ Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and piaca, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, In my opinion, deeth occurred at the time, date and pieca, and due to the cause(s) end manner stated.

29b. Signature end title of certifier: [signature] M.D.
29c. License number: D39793
29d. Dete signed (Month, Dey, Year): March 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Christopher J. Mays, MD 12102 Grafic Ave Wheaton MD 20902

**State Registrar**

31. Date filed (Month, Day, Year): MAR 16 2001
32. Registrar's Signature: [signature]

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

DHMH 16 Rev 6/95

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09347

Collins, Sylvester

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Sylvester Collins
2. Date of Death: Month March Day 06 Year 2001
3. Time of Death: 06:15
4a. Facility Name (If not institution, give street and number): Deaton Specialty Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

**Funeral Director**

5. Social Security Number: 218-62-5490
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 46 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec 19, 1954
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 819 W. Saratoga Street
10f. Zip Code: 21201
10g. Citizen of What Country?: United States

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 9 — College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Waste Collector
16b. Kind of Business/Industry: Baltimore County Government
17. Father's Name (First, Middle, Last): Sylvester Knox
18. Mother's Name (First, Middle, Maiden Surname): Henrietta Collins
19a. Informant's Name/Relationship (Type, Print): Henrietta Bronwxon /Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): #402, 751 W. Saratoga Street, Baltimore, MD 21201
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory — Date: Mar 12 2001
20c. Location - City or Town, State: Beltsville, MD
21. Signature of Funeral Service Licensee: [signature] M00986
22. Name and Address of Facility: Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, MD

**Physician /Medical Examiner**

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. SEVERE WASTING & DEHYDRATION (MYCOBACTERIUM AVIUM)
Due to (or as a consequence of):
DISSEMINATED MAI INFECTION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c. ADVANCED AIDS
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
PERIPHERAL NEUROPATHY, PERI-RECTAL HSV-II

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No
25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: D52394
29d. Date signed (Month, Day, Year): MARCH 6, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ilg Mulasi MD, 29 S. Greene Street, suite 300, Baltimore MD 21201

**State Registrar**

31. Date filed (Month, Day, Year): MAR 13 2001
32. Registrar's Signature: [signature] B. Sparks

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. b

To Be Completed by Funeral Director

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

3

DHMH 16 Rev 6/95

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09348

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): VICTORIA J. CLARKE

2. Date of Death: Month MARCH Day 10 Year 2001

3. Time of Death: 1935

4a. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

**Funeral Director**

5. Social Security Number: 138-14-8731

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov 1, 1922

9. Birthplace (State or Foreign Country): Massachusetts

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Gaithersburg

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 19310 Club House Road, #523

10f. Zip Code: 20886

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Reservations Agent

16b. Kind of Business/Industry: American Airlines

17. Father's Name (First, Middle, Last): Gustaf A. Johnson

18. Mother's Name (First, Middle, Maiden Surname): Amelia Westerlin

19a. Informant's Name/Relationship (Type, Print): Scott Clarke, Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 200 Water Street, #100 Gaithersburg, MD 20877

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Parklawn Memorial Park

Date: Mar 14, 2001

20c. Location - City or Town, State: Rockville, Maryland

21. Signature of Funeral Service Licensee: Tracy A. Stuver

22. Name and Address of Facility: DeVol Funeral Home, 10 E. Deer Park Dr., Gaithersburg, MD 20877

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. MULTIPLE INTERNAL INJURIES

Due to (or as a consequence of): b. AUTO ACCIDENT

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as e consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year): MARCH 10 2001

28b. Time of Injury: N 1900 M

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: PASSENGER IN CAR T-BONED ON (L) TURN

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): STREET

28f. Location (Street and Number or Rural Route Number, City or Town, State): MONTGOMERY VILLAGE AVENUE & CLUBHOUSE ROAD, GAITHERSBURG, MD

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD (OME)

29c. License number: 015236

29d. Date signed (Month, Day, Year): MARCH 10, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CARL I. MARGOLIS, MD (OME) 1125 ROCKVILLE PIKE, ROCKVILLE, MD 20852

**State Registrar**

31. Date filed (Month, Day, Year): MAR 12 2001

32. Registrar's Signature: B. Sparks

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

2001 09349
Reg. No.

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Eleanor Marie Kubilis Cavanaugh
2. Date of Death (Month, Day, Year): March 13, 2001
3. Time of Death: 2:48P.
4a. Facility Name (If not institution, give street and number): 106N. Hollins Ferry Road
4b. City, Town, or Location of Death: Ferndale
4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 218-12-4766
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 10,1922
9. Birthplace (State or Foreign Country): Maryland

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Ferndale
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 106N. Hollins Ferry Road
10f. Zip Code: 21061
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: United Way

17. Father's Name (First, Middle, Last): Joseph Kubilis, Jr.
18. Mother's Name (First, Middle, Maiden Surname): Josephine Matulis

19a. Informant's Name/Relationship (Type, Print): George Cavanaugh - son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): same as #10 a - 10 g

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Memorial Park | Date: 3/17/2001
20c. Location - City or Town, State: Elkridge,Maryland

21. Signature of Funeral Service Licensee: ▶ Donald V Borgwardt
22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Lung Cancer — Due to (or as a consequence of): — 6 mo.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. — Due to (or as a consequence of):
c. — Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ GYO
29c. License number: D25654
29d. Date signed (Month, Day, Year): March 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Young Oh, M.D. 1412 Crain Highway, #6A Glen Burnie, Maryland 21061

**State Registrar**

31. Date filed (Month, Day, Year): MAR 16 2001
32. Registrar's Signature: ▶ B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09350

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Frances L. Denham

2. Date of Death: Month March, Day 13, Yaer 2001

3. Time of Death: 10:22pm

4a. Facility Name (If not Institution, give street and number): Lorien Nursing Home

4b. City, Town, or Location of Death: Mt. Airy

4c. County of Death: Carroll

**Funeral Director**

5. Social Security Number: 036-14-4359

6. Sex: 1☐ M 2☒ F

7. Aga (In yrs. last birthday): 87 Yrs. | If Under 1 Yaar: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Dete of Birth (Month, Day, Year): Jan. 1 1914

9. Birthplace (State or Foreign Country): New York

Usual Residence ot Decedant

10a. Stata: Maryland

10b. County: Carroll

10c. City, Town or Location: Mt. Airy

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 713 Midway Avenue

10f. Zip Coda: 21771

10g. Citizan of What Country?: United States

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Giva Yaer or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:

14. Raca - American Indian, Black, White, atc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elamentary/Secondary (0-12): 12; Collega (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Receptionist

16b. Kind of Business/Industry: Doctors office

17. Fathar's Nama (First, Middle, Last): Leon Johnston

18. Mother's Nama (First, Middle, Maiden Surname): Lydia Jarvela

19a. Informant's Name/Raletionship (Type, Print): Christopher J.Denham III/ Son

19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12304 Dancrest Drive, Clarksburg, Maryland 20871

20a. Mathod ot Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematorium Inc

Date: 3/15/2001

20c. Location - City or Town, Stata: Alexandria,Virginia

21. Signeture of Funaral Service Licensee: ▶ [signature]

22. Nama and Address of Facility: Olin L. Molesworth P. A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872

**Physician /Medical Examiner**

23a. Part1. Entar tha disaase, or complications that caused tha daath. Do not antar tha mode of dying, such as cardiac or raspiretory arrast, shock, or heert tailure. List only ona cause on aach lina.

Approximata Intarval Batween Onsat and Death

Immedieta Causa (Finel diseasa or condition resulting in death):
a. OSTEOMYELITIS LEFT HEEL — 1 MONTH

Dua to (or as a consequence ot):
b. HYPERTENSION — YEARS

Sequentially list conditions, if any, leading to immadiata cause. Entar Undarlying Cause (Disaasa or injury that initiated events resulting in death) Last
Dua to (or es a consequenca of):
c. HYPOTHYROIDISM — YEARS

Dua to (or as a consequance ot):
d. ANGINA

Part II. **Other significant conditions** contributing to death but not rasulting in the undarlying causa given in Part I.: DEMENTIA

23b. Did tobacco use contributa to the causa of death? 1☐ Yas 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No

24b. Ware autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was casa raterred to medical examinar? 1☐ Yes 2☐ No

26. Placa of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Rasidance 6☐ Othar (Specify)

27. Mannar of Death: 1☐ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be datarmined

28a. Data ot Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, street, factory, offica building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Cartifier (Check only one): 1☐ **Certifying Physician:** To the best ot my knowledge, deeth occurred at tha time, deta and placa, end due to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of axamination and/or invastigetion, in my opinion, deeth occurrad at tha time, date and place, and due to the cause(s) and mannar statad.

29b. Signatura and titla ot cartifier: ▶ [signature]

29c. Licansa number: D0053150

29d. Data signed (Month, Day, Year): MARCH 14TH 2001

30. Nama and address of person who completed causa ot death (Item 23a) (Type, Print): SHAKUNTALA GUPTA M.D 201-109 BACK RIVER NECK ROAD BALTIMORE MD 21221

**State Registrar**

31. Dete filed (Month, Day, Year): MAR 16 2001

32. Registrar's Signatura: ▶ [signature]

DHMH 16 Rav 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09351

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Michael Austin Denevan

2. Date of Death: Month: March Day: 12 Year: 2001

3. Time of Death: 9:42 p.m

4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: n/a

**Funeral Director**

5. Social Security Number: 215-56-6467

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 56 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 13, 1944

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince Georges

10c. City, Town or Location: College Park

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 8706 49th Avenue

10f. Zip Code: 20740

10g. Citizen of What Country? United States

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): not applicable

16b. Kind of Business/Industry: not applicable

17. Father's Name (First, Middle, Last): Vincent Edward Denevan

18. Mother's Name (First, Middle, Maiden Surname): Leota Margaret Askew

19a. Informant's Name/Relationship (Type, Print): Francis John Denevan - brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): same as #10a - 10g

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Resurrection Cemetery

Date: 3/15/2001

20c. Location - City or Town, State: Clinton, Maryland

21. Signature of Funeral Service Licensee: ▶ Donald V Borgwardt

22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Road Beltsville, Maryland 20705

**Physician /Medical Examiner**

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

b. Chronic obstructive pulmonary disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Sepsis

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

28. Place of Death (Check only one): Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 [✓] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Rajiv Doshi MD

29c. License number: RES 000

29d. Date signed (Month, Day, Year): March 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Rajiv Doshi MD Sinai Hospital of Baltimore Baltimore, Maryland 21209 Belvedere and Greenspring Avenue

**State Registrar**

31. Date filed (Month, Day, Year): MAR 14 2001

32. Registrar's Signature: ▶ G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

Patient known as Michael Denevan

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

6

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09352

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Paul Gene Darroch

2. Date of Death: Month March, Day 14, Year 2001

3. Time of Death: 5:30 AM

4a. Facility Name (If not institution, give street and number): 10000 Montauk Avenue

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 244-50-4604

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 67 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): Aug 9, 1933

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Bethesda

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 10000 Montauk Avenue

10f. Zip Code: 20817

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No. If Yes, Give Year or Dates: 1954-1956

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner

16b. Kind of Business/Industry: Barber Shops

17. Father's Name (First, Middle, Last): J.W. Darroch, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Effie Jane Ray

19a. Informant's Name/Relationship (Type, Print): Nina S. Darroch/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10000 Montauk Avenue, Bethesda, Maryland 20817

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion Cemetery

Date: Mar. 18 2001

20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: David E. Percy, M00803

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave. Bethesda, maryland 20814-3501

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Carcinoma of the Bladder — 1½ Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Richard H Pollen MD

29c. License number: D09577

29d. Date signed (Month, Day, Year): March 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Richard H. Pollen, M.D. 10400 Connecticut Avenue, #606, Kensington, MD 20895

**State Registrar**

31. Date filed (Month, Day, Year): MAR 16 2001

32. Registrar's Signature: Brenda G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

6+1

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09353

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: William F. Dalton
2. Date of Death Month Day Year: March 11, 2001
3. Time of Death: 5:30 am
4a. Facility Name *(If not institution, give street and number)*: Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 031-10-9162
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Dec 12, 1915
9. Birthplace *(State or Foreign Country)*: Massachusetts

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 11710 Georgia Avenue
10f. Zip Code: 20902
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yaar or Datas: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Giva kind of work done during most of working life. DO NOT use retired)*: Court Reporter
16b. Kind of Business/Industry: Government

17. Father's Name *(First, Middle, Last)*: William F. Dalton
18. Mothar's Name *(First, Middle, Maiden Surname)*: Catherine M. Curry

19a. Informant's Name/Relationship *(Type, Print)*: Juliette P. Dalton / Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 11710 Georgia Avenue, Silver Spring, MD 20902

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Ramoval from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or othar place)*: Gate of Heaven Cemetery
Date: March14 2001
20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funaral Sarvice Licensaa: James E Dodge
22. Nama and Addrass of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not anter tha mode of dying, such as cardiac or raspiratory arrest, shock, or heart tallure. List only one cause on each line. — Approximata Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cardiac Arrhythmia

Due to (or as a consequence ot):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No

24b. Wera autopsy findings available prior to completion ot cause ot death? 1 [ ] Yes 2 [X] No

25. Was cese referred to medicel examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Homa 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, tarm, street, tactory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. Licensa number: D 054566
29d. Data signed *(Month, Day, Year)*: March 11, 2001

30. Nama and address of person who completed ceuse ot death (Item 23a) (Type, Print): Sunitha Bhogavilli, MD 8609 2nd Avenue, Silver Spring, MD 20910, Suite 404B

**State Registrar**

31. Data filed *(Month, Day, Year)*: MAR 12 2001
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28d-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

18 5

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09354

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): MARIAN STONESIFER EYLER
2. Date of Death (Month, Day, Year): MARCH 11, 2001
3. Time of Death: 4:20 A.M.

4a. Facility Name (If not Institution, give street and number): GLADE VALLEY NURSING & REHAB. CENTER
4b. City, Town, or Location of Death: WALKERSVILLE
4c. County of Death: FREDERICK

**Funeral Director**

5. Social Security Number: 219-12-2345
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): APR.14,1917
9. Birthplace (State or Foreign Country): EMMITSBURG, MD.

Usual Residence of Decedent

10a. State: MD
10b. County: FREDERICK
10c. City, Town or Location: EMMITSBURG
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 130 W. MAIN ST.
10f. Zip Code: 21727
10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): MAHLON STONESIFER
18. Mother's Name (First, Middle, Maiden Surname): ANNA FUSS

19a. Informant's Name/Relationship (Type, Print): H. EUGENE EYLER / SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8428 HEMLER RD. THURMONT, MD. 21788

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): EMMITSBURG MEMORIAL | Date: 3/14/01
20c. Location - City or Town, State: EMMITSBURG, MD. 21727

21. Signature of Funeral Service Licensee: John M Skiles
22. Name and Address of Facility: SKILES FUNERAL HOME 210 W. MAIN ST. POB 427, EMMITSBURG, MD. 21727

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | e. Aspiration Pneumonitis | 2 week |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Dysphagia | 1 year |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Alzheimers Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D43091
29d. Date signed (Month, Day, Year): 3-12-01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): SAEED ZAIDI 801 TOLL HOUSE AVE, FREDERICK, MD

**State Registrar**

31. Date filed (Month, Day, Year): MAR 12 2001
32. Registrar's Signature: Geneva B Sparks

DHMH 16 Rev 6/95

---

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09355

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Isabelle I. Enyart

2. Date of Death Month Dey Year: March 11, 2001

3. Time of Death: 8:35 am

4a Facility Name *(If not institution, give street and number)*: Suburban Hospital

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 226-28-5881

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthdey)*: 77 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Day, Year)*: Nov 9, 1923

9. Birthplace *(Stete or Foreign Country)*: Virginia

Usuel Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 10820 Georgia Avenue, Apt T18

10f. Zip Code: 20902

10g. Citizen of What Country?: USA

11. Merital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Rece - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Secretary

16b. Kind of Business/Industry: Federal Government

17. Father's Name *(First, Middle, Last)*: Calvin Leslie Irvin, Sr.

18. Mother's Neme *(First, Middle, Maiden Sumame)*: Pearl Marks

19e. Informent's Name/Reletionship *(Type, Print)*: Virginia Pettit/ Cousin

19b. Melling Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 14025 Brighton Dam Road, Clarksville, MD 21029

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donation 5☐ Other *(Specify)*

20b. Ptece of Disposition *(Neme of cemetery, cremetory or other piece)*: Arlington National Cemetery

Date: Mar 20 2001

20c. Location - City or Town, State: Arlington, VA

21. Signature of Funerel Service Licensee: James E. Dooley

22. Neme end Address of Fecility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Silver Spring, MD 20901

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complicetions thet ceused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximate interval Between Onset and Deeth

Immediete Cause (Final disease or condition resulting in death): a. METASTATIC BREAST CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last

b.

Due to (or es a consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yee 2☒ No 3☐ Probably 4☐ Unknown

24e. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was casa referred to medicel exeminer? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end place, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(a) and menner steted.

29b. Signature end title of certifier: Carolyn Hendricks

29c. License number: D37236 #305

29d. Dete signed *(Month, Dey, Year)*: MARCH 11, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): CAROLYN HENDRICKS MD 6410 ROCKLEDGE DR BETHESDA MD 20817

**State Registrar**

31. Date filed *(Month, Dey, Year)*: MAR 13 2001

32. Registrar's Signeture: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Enyart, Isabelle I. 3/11/01

12

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09356

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Robert Clifton Frye

2. Date of Death: Month March Day 13, Year 2001

3. Time of Death: 8:20 am

4a. Facility Name (If not institution, give street and number): Northampton Manor Nursing Center

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

**Funeral Director**

5. Social Security Number: 220-26-0476

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug 18, 1913

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 213 Monroe Avenue

10f. Zip Code: 21701

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 5 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Processing Technician

16b. Kind of Business/Industry: Milk Production

17. Father's Name (First, Middle, Last): Lee Theodore Frye

18. Mother's Name (First, Middle, Maiden Surname): Ellen Leona Stocks

19a. Informant's Name/Relationship (Type, Print): Mrs. Mary Catherine Main/Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 506 Military Road, Frederick, Maryland 21702

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt Olivet Cemetery | Date: Mar 16,2001

20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: Kathryn R. Bezard M00706

22. Name and Address of Facility: Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Bowel obstruction — 2 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Severe COPD

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D21944

29d. Date signed (Month, Day, Year): March 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James S. Grissom, M.D., 300 West Ninth Street, Frederick, Maryland 21701

**State Registrar**

31. Date filed (Month, Day, Year): MAR 15 2001

32. Registrar's Signature: Donna B Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 09357

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: MYER FRIEDBERG
2. Date of Death Month Day Year: MARCH 7, 2001
3. Time of Death: 6:00 A M
4a. Facility Name *(If not institution, give street and number)*: HOLY CROSS HOSPITAL
4b. City, Town, or Location of Death: SILVER SPRING
4c. County of Death: MONTGOMERY

**Funeral Director**

5. Social Security Number: 578.24.4322
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 77 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 11.20.1923
9. Birthplace *(State or Foreign Country)*: VIRGINIA

Usual Residence of Decedent

10a. State: MD
10b. County: MONTGOMERY
10c. City, Town or Location: SILVER SPRING
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1400 FENWICK LANE #109
10f. Zip Code: 20910
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No
If Yes, Give Year or Dates: 1943-46
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education *(Specify only highest grade completed)*
Elementary/Secondary (0-12):
College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SCHOOL TEACHER
16b. Kind of Business/Industry: PUBLIC SCHOOLS

17. Father's Name *(First, Middle, Last)*: MORRIS FRIEDBERG
18. Mother's Name *(First, Middle, Maiden Surname)*: SARAH KAPLAN

19a. Informant's Name/Relationship *(Type, Print)*: STACEY FRIEDBERG/SON
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1618 BRITTLE BRANCH WAY, WOODBINE, MARYLAND 21797

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: ARLINGTON NATIONAL
Date: MARCH 15, 2001
20c. Location - City or Town, State: ARLINGTON, VA

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | CARDIAC ARREST | IMMEDIATE |
| Due to (or as a consequence of): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. | MULTILOBAR PNEUMONIA | 3 WEEKS |
| Due to (or as a consequence of): | | |
| c. | SQUAMOUS CELL CARCINOMA OF THE LUNG | UNKNOWN |
| Due to (or as a consequence of): | | |
| d. | | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other *(specify)* _____ 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23a. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
28. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Kristie Hinson MD
29c. License number: D0056153
29d. Date signed *(Month, Day, Year)*: MARCH 9, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KRISTIE HINSON, MD 12001 FERRARA AVE, WHEATON, MARYLAND 20906

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 13 2001
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 09358

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: PEARL FRANKLIN
2. Date of Death Month Day Year: MARCH 15, 2001
3. Time of Death: 9:05 AM
4a. Facility Name *(If not institution, give street and number)*: HEBREW HOME OF GREATER WASHINGTON
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

**Funeral Director**

5. Social Security Number: 089-14-8937
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 95 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 03.21.1905
9. Birthplace *(State or Foreign Country)*: RUSSIA

Usual Residance of Decedant

10a. State: MARYLAND
10b. County: MONTGOMERY
10c. City, Town or Location: ROCKVILLE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6121 MONTROSE ROAD
10f. Zip Code: 20852
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yas, Giva Year or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, atc. *Specify:* WHITE

15. Decedent's Education *(Specify only highast grada completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Giva kind of work done during most of working lifa. DO NOT use retired)*: HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Fathar's Nama *(First, Middle, Last)*: JACOB WEISSMAN
18. Mothar's Nama *(First, Middle, Maiden Surnama)*: ETHEL OBSIANIKER

19a. Informant's Name/Relationship *(Type, Print)*: JUDITH R. GORDON/DAUGHTER
19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 15320 PINE ORCHARD DRIVE, SILVER SPRING, MD 20906

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Othar *(Specify)*
20b. Place of Disposition *(Nama of cematary, crematory or other place)*: MOUNT LEBANON CEMETERY — Data: MAR 18, 2001
20c. Location - City or Town, Stata: ADELPHI, MARYLAND

21. Signature of Funeral Service Licensee: [signature]
22. Nama and Address of Facility: EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not entar tha mode of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona cause on aach lina. — Approximata intarval Batween Onsat and Daath

Immediate Causa (Final disaasa or condition rasulting in daath)
a. ACUTE MYOCARDIAL INFARCTION
Dua to (or as a consequence of):
Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disaasa or injury that initiated evants rasulting in death) Last
b.
Dua to (or as a consequence of):
c.
Dua to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.: MULTI-INFARCT DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Ware autopsy findings available prior to completion of cause of daath? 1☐ Yas 2☐ No

25. Was casa rafarrad to medical examiner? 1☐ Yas 2☒ No

26. Place of Death *(Check only ona)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Othar *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding investigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At homa, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☒ **Certifying Physician**: To tha best of my knowledge, death occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner**: On tha basis of axamination and/or investigation, in my opinion, death occurred at tha tima, data and piace, and dua to tha cause(s) and manner stated.

29b. Signatura and titla of cartifiar: [signature] M.D.
29c. License number: D18084
29d. Data signed *(Month, Day, Year)*: MARCH 15, 2001

30. Nama and address of person who completed cause of death (Item 23a) *(Type, Print)*: D.D. PATEL, M.D. 6121 Montrose Rd, Rockville, MD 20852

**State Registrar**

31. Data filed *(Month, Day, Year)*: MAR 16 2001
32. Registrar's Signatura: [signature]

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Amend #10e, 3/22/2001, BMW, Montg.Co.

# Certificate of Death

Reg. No. 2001 09359

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Lillian Krakower Fisk | March 12, 2001 | 9:05P. |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Suburban Hospital | Bethesda | Montgomery |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (in yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 102-32-4901 | 1☐ M 2☒ F | 92 Yrs. | | | Sept. 7, 1908 | New York |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Montgomery | Rockville | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| ~~6011~~ 6111 Montrose Road, #907 | 20852 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 5+ | Teacher | Education |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Aaron Krakower | Rebecca Aaronson |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Joan Gorman - Daughter | 11623 Deborah Drive Potomac, Maryland 20854 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Judean Memorial Garden | 3/15/2001 | Olney, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| [signature] | Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Septicemia | 4 days |
| Due to (or as a consequence of): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. | Pneumonia | 9 days |
| Due to (or as a consequence of): | | |
| c. | | |
| Due to (or as a consequence of): | | |
| d. | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia

Advanced age

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in *my* opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] Michael Emmer M.D | D 05120 | 3/13/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Michael Emmer, M.D. 6316 Democracy Blvd. Bethesda, Maryland 20817

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 14 2001 | [signature] B. Sparks |

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0020**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Fisk, Lillian 3-12-01 2105 GF

15

01-1368-021
mnmr
Alan Guttenplan

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09360

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| ALAN | HARVEY | GUTTENPLAN | March 10, 2001 | 1634 p M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Frederick Memorial Hospital | Frederick | Frederick |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 408-17-0208 | 1☒M 2☐F | 40 Yrs. | | | June 1, 1960 | Massachusetts |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Frederick | Frederick | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 184 Fairfield Drive | 21702 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 2 | Marketing | Computers |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Mitchell Guttenplan | Jacqueline Goldstein |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Cheryl L. Guttenplan / wife | 184 Fairfield Dr./ Frederick, Maryland 21702 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Pleasant Hill Cem. | 03/13/2001 | Monrovia, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Raymond Peterson | Stauffer Funeral Home 1621 Opossumtown Pike/ Frederick, MD 21702 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC TAMPONADE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

b. RUPTURED ASCENDING AORTIC DISSECTING ANEURYSM

Due to (or as a consequence of):

c. HYPERTENSIVE CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Data of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☐No 3☐Probably 4☒Unknown | 1☒Yes 2☐No | 1☒Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☒Yes 2☐No | Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| M.D. | O.C.M.E. | March 11, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mary C. Ripple, M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 12 2001 | Geneva G Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or Item 23a or 28e-I show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 09361

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): CHARLES Robert GERMROTH
2. Data of Death Month: MARCH Day: 11 Year: 2001
3. Time of Death: 934 PM
4a. Facility Name (If not institution, give street and number): University of MARYLAND
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: Baltimore City

**Funeral Director**

5. Social Security Number: 220-58-3872
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 47 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): June 19, 1953
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 8007A Edgewood Church Road
10f. Zip Code: 21702
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Salesman
16b. Kind of Business/Industry: Insurance

17. Father's Name (First, Middle, Last): Charles Morley Germroth
18. Mother's Name (First, Middle, Maiden Surname): Phyllis Elizabeth Titlow

19a. Informant's Name/Relationship (Type, Print): Dianne Pryor / sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12511 Loy Wolfe Road, Myersville, Maryland 21773

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Lawn Memorial Prk Date: 3-16-2001
20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Patty L Perkins
22. Name and Address of Facility: Ricketts Funeral Home 504 Main Street Myersville, MD 21773

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis
Due to (or as a consequence of):
b. Liver Failure — 4 days
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23a. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one)
Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: P381234
29d. Date signed (Month, Day, Year): 3/11/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GARRETTSON ELLIS, MD 22 S. Greene St BALTIMORE MD 21201

**State Registrar**

31. Date filed (Month, Day, Year): MAR 15 2001
32. Registrar's Signature: Geneva B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Amend Item#1 perPHY,#8 perFHG796 6/8/01 EW

# Certificate of Death

Reg. No. 2001 09362

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Natalija Jovan Gajin ~~Grajin~~
2. Date of Death: Month March Day 11, Year 2001
3. Time of Death: 5:30 pm
4a. Facility Name (If not institution, give street and number): Northampton Manor Nursing Center
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

**Funeral Director**

5. Social Security Number: 217-06-5373
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 92 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 8 ~~20~~, 1908
9. Birthplace (State or Foreign Country): Yugoslavia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Jefferson
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4405 Holter Court
10f. Zip Code: 21755
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): self
16b. Kind of Business/Industry: homemaker

17. Father's Name (First, Middle, Last): Jovan Saric
18. Mother's Name (First, Middle, Maiden Surname): Persida Sibinkic-Nikolic

19a. Informant's Name/Relationship (Type, Print): (daughter) Draginja Djurickovic-Fish
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4405 Holter Court, Jefferson, MD 21755

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Zion Lutheran Cemetery
Date: 3/14/2001
20c. Location - City or Town, State: Middletown, Maryland

21. Signature of Funeral Service Licensee: Ryan M. Berger MO0999
22. Name and Address of Facility: Keeney and Basford Funeral Home, 106 East Church Street, Frederick, MD 21701

**Physician /Medical Examiner**

23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CVA — 10 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: Robert L. Kaufmann
29c. License number: D13971
29d. Date signed (Month, Day, Year): March 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert L. Kaufmann, 300 W. Ninth Street, Frederick, MD 21701

**State Registrar**

31. Date filed (Month, Day, Year): MAR 13 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

2001 09363
Reg. No.

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Janice Elizabeth Geisbert
2. Date of Death Month Day Year: March 12, 2001
3. Time of Death: 3:45 PM M
4a. Facility Name *(If not institution, give street and number)*: Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

**Funeral Director**

5. Social Security Number: 220-26-0719
6. Sex: 1 ☐ M 2 ☒ F
7. Age *(In yrs. last birthday)*: 66 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 5, 1934
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10e. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Myersville
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 10612 Highland School Road
10f. Zip Code: 21773
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Deli Manager
18b. Kind of Business/Industry: Grocery Store

17. Father's Name *(First, Middle, Last)*: Leo Brandenburg
18. Mother's Name *(First, Middle, Maiden Surname)*: Ruth Amelia Kuhn

19e. Informant's Name/Relationship *(Type, Print)*: Calvin M. Geisbert (Husband)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10612 Highland School Road, Myersville, MD 21773

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Bethel Cemetery
Date: 3/16/01
20c. Location - City or Town, State: Foxville, Maryland

21. Signature of Funeral Service Licensee: Robert E. Dailey
22. Name and Address of Facility: ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701

**Physician /Medical Examiner**

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only one cause on aech line.

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE MYOCARIAL INFARCTION — Approximate Interval Between Onset and Death: 45 min

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Last
Due to (or as e consequence of):
b. AORTIC OCCLUSION — 4 HRS
Due to (or as a consequence of):
c. DEHYDRATION — 5-7 DAYS
Due to (or as a consequence of):
d. CITRUS COLITIS — > 14 DAYS

IF FEMALE:
23b. Was decedent pregnant in the pest 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetel deeth 3 ☐ Ectopic pregnancy 4 ☐ Pregnent at time of deeth 5 ☐ Other *(specify)* 9 ☐ Unknown
23d. Data of delivery Month Day Year

Part II. **Other significant conditions** contributing to daath but not rasulting in the underlying causa given in Part I.
CORONARY ARTERY DISEASE
ATHEROSCLEROSIS OF THE AORTA

23e. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
24a. Was en autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were eutopsy findings availabla prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Wes case referred to medical examiner? 1 ☒ Yes 2 ☐ No
28. Place of Death *(Check only one)*: Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Homa 5 ☐ Residence 8 ☐ Othar *(Specify)*

27. Menner of Death: 1 ☒ Netural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Dete of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury et Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rurel Routa Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete end piece, and due to the cause(s) and menner as steted. 2 ☐ **Medical Examiner:** On the basis of exeminetion end/or investigation, in my opinion, death occurred et the time, date and piece, end due to tha ceuse(s) end mannar stated.
29b. Signature and title of certifier: Paul M. McNeill
29c. License number: D0045892
29d. Dete signed *(Month, Day, Yaer)*: 3/12/01
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Paul M. McNeill, 501 West 7th Street, Frederick, Maryland 21701

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 14 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09364

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Gertrude M. Gonzales

2. Date of Death Month Day Year: March 12, 2001

3. Time of Death: 10:55 PM

4a. Facility Name *(If not institution, give street and number)*: Brooke Grove Nursing Center

4b. City, Town, or Location of Death: Olney

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 577-01-2520

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 89 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 25, 1911

9. Birthplace *(State or Foreign Country)*: Washington, D.C.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Damascus

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 25829 Woodfield Road

10f. Zip Code: 20872

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Supervisor

16b. Kind of Business/Industry: Telephone Company

17. Father's Name *(First, Middle, Last)*: James Joseph Bell

18. Mother's Name *(First, Middle, Maiden Surname)*: Mamie Hines

19a. Informant's Name/Relationship *(Type, Print)*: Alma Hughes - Niece

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 25829 Woodfield Road, Damascus, Maryland 20872

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery

Date: 3/16/01

20c. Location - City or Town, State: Silver Spring, Maryland

21. Signature of Funeral Service Licensee: Kurt L. Williams

22. Name and Address of Facility: Olin L. Molesworth P.A., Funeral Home, 26401 Ridge Road, Damascus, Maryland 20872

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ASPIRATION PNEUMONIA — 2 DAYS

Due to (or as a consequence of):

b. DYSPHAGIA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. ADVANCED SENILE DEMENTIA — YEARS.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

**Medical Certification: To Be Completed by Physician/Medical Examiner**

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ted Howe. MD

29c. License number: D33700

29d. Date signed *(Month, Day, Year)*: MARCH 13, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): TED HOWE 154 N. ARTIZAN ST, WILLIAMSPORT, MD 21795

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 14 2001

32. Registrar's Signature: Geneva G Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09365

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| Shirley | Barry | Gooden | March 12, 2001 | 4:00 am |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Glade Valley Nursing & Rehab Center | Walkersville | Frederick |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 579-38-9561 | 1☐ M 2☒ F | 70 Yrs. | | | May 15, 1930 | Washington, D.C. |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Montgomery | Gaithersburg | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 12310 Sour Cherry Way | 20878 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Switchboard Operator | Telephone Company |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Griffith C. Barry | Margaret Elmore |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Carol M. Lewis/Daughter | 12310 Sour Cherry Way, Gaithersburg, MD 20878 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | George Washington Cemetery | March 14, 2001 | Adelphi, Maryland |

21. Signature of Funeral Service Licensee: ▶ Will E Bowers Jr M00672

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. COPD | years |
| Due to (or as a consequence of): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. | |
| Due to (or as a consequence of): | | |
| | c. | |
| Due to (or as a consequence of): | | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Osteoporosis

23b. **Did tobacco use contribute to the cause of death?** 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ | D26516 | MARCH 12, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Allen J. Gleser MD 1475 TAMEY AVE FREDERICK MD 21702

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 16 2001 | ▶ B. Sparks |

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09366

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Luis M. Gonzalez
2. Date of Death (Month, Day, Year): March 8, 2001
3. Time of Death: 725am
4a. Facility Name (If not institution, give street and number): Hebrew Home of Greater Washington
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 061-34-0422
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 96 Yrs. | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min.
8. Date of Birth (Month, Day, Year): Jan 10, 1905
9. Birthplace (State or Foreign Country): Cuba

Usual Residence of Decedent

10a. State: NA
10b. County: NA
10c. City, Town or Location: Washington D.C.
10d. Inside City Limits: X 1 ☐ Yes 2 ☐ No
10e. Street and Number: 1331 Rittenhouse St. NW
10f. Zip Code: 20011
10g. Citizen of What Country? United States

11. Marital Status: X 3 ☐ Widowed 1 ☐ Never Married 2 ☐ Married 4 ☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) X 1 ☐ Yes 2 ☐ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Musician
16b. Kind of Business/Industry: Entertainment

17. Father's Name (First, Middle, Last): Ignacio Gonzalez
18. Mother's Name (First, Middle, Maiden Surname): Juana Varona

19a. Informant's Name/Relationship (Type, Print): Estela Barry /Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1714 Evelyn Dr., Rockville, MD 20852

20a. Method of Disposition: X 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Olivet Cemetery
Date: Mar 13 2001
20c. Location - City or Town, State: Washington D.C.,

21. Signature of Funeral Service Licensee: Lewis A. Shady
22. Name and Address of Facility: Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, MD

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. cardiorespiratory Arrest
Due to (or as a consequence of):
b. Congestive heart failure
Due to (or as a consequence of):
c. Pneumonia
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
hypertension, hypothyroidism
dementia

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.
29b. Signature and title of certifier: John Selwa MD
29c. License number: D0055362
29d. Date signed (Month, Day, Year): 03-08-01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Irina Selya MD; 6121 Montrose Rd., Rockville, MD. 20852

**State Registrar**

31. Date filed (Month, Day, Year): MAR 16 2001
32. Registrar's Signature: Lewis G. Sparks

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28d show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit copy.

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09367

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Alma B. Gerhold

2. Date of Death: Month March Day 07, Year 2001

3. Time of Death: 8:53 PM

4a. Facility Name (If not institution, give street and number): Fox Chase Nursing & Rehabilitation

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 578-40-1169

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 94 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Apr 5, 1906

9. Birthplace (State or Foreign Country):

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2015 East West Hwy.

10f. Zip Code: 20910

10g. Citizen of What Country? United States

11. Meritel Stetus: 1☐ Never Married 2☐ Merried ☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondery (0-12): 0

College (1-4or 5+):

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): John (Unknown)

18. Mother's Name (First, Middle, Maiden Surnama): Olivia (Unknown)

19a. Informant's Name/Relationship (Type, Print): Chris Walker /Attorney

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11921 Rockville Pike, 3rd Floor, Rockville, MD

20a. Method of Disposition: ☒1 Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Rock Creek Cemetery

Date: Mar 13 2001

20c. Location - City or Town, State: Washington, DC

21. Signature of Funeral Service Licensee: ▶ Beverly L. Herbotte

22. Name and Address of Facility: Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, MD

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Breast Cancer — Years

Due to (or as a consequenca of):

b. Electrolyte Abnormality — Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequenca of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobecco use contribute to the cause of death? 1☐ Yaa 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medicat examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶

29c. License number: D0050987

29d. Dete signed (Month, Day, Year): 3-12-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ahmed Nawaz M.D. 1299 Lamberton Dr, Silver Spring, MD 20902

**State Registrar**

31. Date filed (Month, Day, Year): MAR 13 2001

32. Registrer's Signeture: ▶ Brenda G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09368

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Miriam Gerber

2. Date of Death Month Day Year: March 8, 2001

3. Time of Death: 8:35 AM

4a. Facility Name *(If not institution, give street and number)*: Hebrew Home of Greater Washington

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 214-12-9729

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Mar. 21, 1920

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 9039 Sligo Creek Parkway

10f. Zip Code: 20901

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Research Analyst

16b. Kind of Business/Industry: Maritime Administration

17. Father's Name *(First, Middle, Last)*: Rubin Seidman

18. Mother's Name *(First, Middle, Maiden Surname)*: Sophie Berkowitz

19a. Informant's Name/Relationship *(Type, Print)*: Martin Seidman/ nephew

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10477 Avenida Ln., Prinera Yuma, AZ 85367

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Arlington Nat. Cem.

Date: Mar. 12, 2001

20c. Location - City or Town, State: Arlington, VA

21. Signature of Funeral Service Licensee ▶

22. Name and Address of Facility: Danzansky- Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, MD 20852

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ADENOCARCINOMA OF PANCREAS — 2 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶ A Patel M.D.

29c. License number: D 18084

29d. Date signed *(Month, Day, Year)*: MARCH 08, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): S. D. PATEL, M.D. 6121 MONTROSE RD, ROCKVILLE, MD 20852

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 13 2001

32. Registrar's Signature ▶ Linda G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

12

01-1361-510
LAWSON GARNETT
ASP

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM 23a,27,28a-f per G796 062001 SS

# Certificate of Death

2001 09369
Reg. No.

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| LAWSON A. GARNETT | MARCH 10 2001 | 0630 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| BAYVIEW HOSPITAL | BALTIMORE | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-52-5109 | 1☒M 2☐F | 51 Yrs. | | | June 1,1949 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Anne Arundel | Severn | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 8363 Pioneer Drive | 21144 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12th | | Laborer | Construction |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Lawson Garnett, II | Dorothy Powell |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Barbara J. Garnett (Wife) | 8363 Pioneer Drive, Severn, MD 21144 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Md. Nat'l Mem. Pk. | 3/16/01 | Laurel, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| George R. Snowden | SNOWDEN FUNERAL HOME, P.A. 246 N. Wash. St., Rockville, MD 20850 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. THERMAL INJURIES WITH COMPLICATIONS | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown | 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | 23d. Date of delivery Month / Day / Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☒Yes 2☐No | 1☒Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☒Yes 2☐No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☒Could not be determined | 3-7-01 | 4:47 AM | 1☐Yes 2☒No | victim of house fire |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| residence | 8363 Pioneer Dr., Severn, MD |

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| J M. T | O.C.M.E | MARCH 11,2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JACK M. TIMS M.D. 111 Penn Street, Baltimore, MarYLAND 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 15 2001 | Donna G. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RKD

01-1282-031

WILLIAM GARNER

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

2001 09370 Reg. No.

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): WILLIAM EVERETTE GARNER

2. Date of Death Month: MARCH Day: 7 Year: 2001

3. Time of Death: 1:50P. M

4a. Facility Name (If not institution, give street and number): HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death: SILVER SPRING

4c. County of Death: MONTGOMERY

**Funeral Director**

5. Social Security Number: 216-44-8876

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 77 Yrs.

If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 19, 1923

9. Birthplace (State or Foreign Country): DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 2201 Colston Drive Apt 303

10f. Zip Code: 20910

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: Korean War

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 4

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Scientist

16b. Kind of Business/Industry: Naval Research Lab

17. Father's Name (First, Middle, Last): Harry Everette Garner

18. Mother's Name (First, Middle, Maiden Surname): Anna Bernardine Kramer

19a. Informant's Name/Relationship (Type, Print): Doris Garner/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2201 Colston Drive, Silver Spring, MD 20910

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory 2001

Date: March 10

20c. Location - City or Town, State: Alexandria, VA

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Arteriosclerotic Cardiovascular Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic Obstructive Pulmonary Disease; Dementia

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): MARCH 8, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Hilton Locke, MD 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): MAR 12 2001

32. Registrar's Signature: [signature] G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09371

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Jose Gamboa

2. Date of Death (Month, Day, Year): Feb. 26, 2001

3. Time of Death: 2:57 PM

4a. Facility Name *(If not institution, give street and number)*: Collingswood Nursg & Rehab. Center

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 578-74-7125

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 21, 1911

9. Birthplace *(State or Foreign Country)*: Chile

Usuet Residence of Decedent

10a. Steta: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 12416 Connecticut Ave.

10f. Zip Code: 20906

10g. Citizen of What Country?: Chile

11. Merital Stetus: 1☐ Never Married 2☐ Merried 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☒ Yes 2☐ No *Specify:* Chilean

14. Reca - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 9 | College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done duning most of working life. DO NOT usa retired)*: General Contractor

16b. Kind of Business/Industry: Construction

17. Father's Name *(First, Middle, Last)*: Miguel Gamboa

18. Mother's Name *(First, Middle, Maiden Surname)*: Filomena Escanilla

19a. Informent's Neme/Retetionship *(Type, Print)*: Veronica Arancibia/Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 14120 Peartree Lane, Silver Spring, MD 20906

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Ptece of Disposition *(Neme of cemetery, crematory or other place)*: Parklawn Cemetery

Dete: March 01 2001

20c. Location - City or Town, State: Rockville, MD

21. Signeture of Funeral Service Licensee: Stephen D. Lohrmann

22. Neme end Address of Facility: Rapp Funeral & Cremation Services
Stephen D. Lohrmann, PA
933 Gist Ave. Silver Spring, MD 20910

**Physician /Medical Examiner**

23a. Pert1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line.

Approximete Interval Between Onset and Deeth

Immedete Ceuse (Finel disease or condition resulting in death)

a. Bilateral Pneumonia

Due to (or es e consequence ot):

b. Alzheimers Disease

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last

Due to (or as e consequence of):

c. Cerebrovascular Accident

Due to (or as a consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.: Hypertension, Parkinson's Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Plece of Deeth *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Othar *(Specify)*

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, deta and place, and due to the cause(s) and menner steted.

29b. Signeture and title of certifier: Wilhelmina Camina M.D.

29c. License number: D21662

29d. Date signed *(Month, Day, Year)*: March 05, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Wilhelmina Camina, M.D. 4912 Adrain Street, Rockville, MD 20853

**State Registrar**

31. Dete filed *(Month, Day, Year)*: MAR 13 2001

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 09372

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| George Edwin Howard, Sr. | March 13, 2001 | 0630 a M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Dorchester General Hospital | Cambridge | Dorchester |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-12-1620 | 1 X M 2 F | 89 Yrs. | | | May 19, 1911 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Dorchester | Cambridge | 1 Yes 2 X No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 933 Hudson Road | 21613 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 Never Married 2 Married 3 X Widowed 4 Divorced | 1 Yes 2 X No If Yes, Give Year or Dates: | 1 Yes 2 X No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 9 | | Maintenance | State Hospital |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| George Henry Howard | Eva Spedden |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| George Edwin Howard, Jr./Son | 5829 Hudson Wharf Rd., Cambridge, MD 21613 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | Spedden-Seward Cemetery | 03-16-2001 | Cambridge, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Curran-Bromwell | Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD 21613 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Pneumonia | days |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. Cerebellar infarct | weeks |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 Yes 2 No 9 Unknown | 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 Yes 2 X No | 1 Yes 2 No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 Yes 2 X No | Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA | Other: 4 Nursing Home 5 Residence 6 Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | | 1 Yes 2 No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| M.A. Moore MD | D 31766 | March 13, 2001 |

30. Name and address of person who completed cause of death (Item 29a) (Type, Print)

Mary Ann D. Moore, M.D. 503 Byrn St, Cambridge MD 21613

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 15 2001 | G. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Amended#4a, 03-13-01, WCHD, dq

# Certificate of Death

Reg. No. 2001 09373

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): CHARLES EDWARD HOLLAND

2. Date of Death: Month 3 Day 4 Year 01

3. Time of Death: 4:05AM

4a. Facility Name (If not institution, give street and number): 1200 DANNETT AVE 1200 Gannett Road

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

**Funeral Director**

5. Social Security Number: 217-52-0321

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 51 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 12-10-49

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD.

10b. County: WICOMICO

10c. City, Town or Location: SALISBURY

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1200 GANNETT ROAD

10f. Zip Code: 21804

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: "69-71"

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) 12; College (1-4or 5+) 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LANDSCAPES

16b. Kind of Business/Industry: SELF-EMPLOYED

17. Father's Name (First, Middle, Last): LEVIN HOLLAND SR.

18. Mother's Name (First, Middle, Maiden Surname): REBECCA SCARBAROUGH HOLLAND

19a. Informant's Name/Relationship (Type, Print): DIANE HOLLAND - WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1200 GANNETT RD. SALISBURY, MD. 21804

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): VETERANS CEMETARY

Date: 3/10/01

20c. Location - City or Town, State: HURLOCK, MD.

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: BENNIE SMITH F/H 917 W. ISABELLA ST. SALISBURY, MD. 21801

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Adenoid cystic jaw cancer — 6 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Asha Murthy MD

29c. License number: AY4635427

29d. Date signed (Month, Day, Year): 3/8/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 22 S GREENE STREET, BALTIMORE, MD 21201

**State Registrar**

31. Date filed (Month, Day, Year): MAR 13 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

SDQ

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09374

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Janet Eileen Husemann
2. Date of Death (Month, Day, Year): March 9, 2001
3. Time of Death: 1:02 PM
4a. Facility Name (If not institution, give street and number): 12802 Teaberry Rd
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 210-20-0880
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jun 12, 1927
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10a. Street and Number: 12802 Teaberry Rd
10f. Zip Code: 20906
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: Dept. of Interior

17. Father's Name (First, Middle, Last): Bert C. Rose
18. Mother's Neme (First, Middle, Maiden Surname): Luella Theis

19a. Informant's Neme/Relationship (Type, Print): Robert W. Husemann/Husband
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 12802 Teaberry Rd, Silver Spring, MD 20906

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, cremetory or other piece): Fort Lincoln Crematory
Date: Mar 13
20c. Location - City or Town, State: Brentwood, MD

21. Signeture of Funeral Service Licensee: Alan J Dannell
22. Name and Address of Facility: Hines-Rinaldi Funeral Home 11800 New Hampshire Ave, Silver Spring, MD 20904

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Respiratory Failure
Due to (or as a consequence of):
b. Parkinsonism
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last
Due to (or as e consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24e. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medicet examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ **Certifying Phyaician**: To the best of my knowledge, deeth occurred at the tima, dete and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signatura and title of certifier: Penny Bisk MD
29c. License number: D25085
29d. Date signed (Month, Dey, Year): March 12, 2001

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print): Penny L. Bisk, MD, 10313 Georgia Ave., Suite 301, Silver Spring, MD 20902

**State Registrar**

31. Date filed (Month, Dey, Year): MAR 15 2001
32. Registrer's Signature: Brenda G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09375

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Riley Evans Hodge

2. Date of Death: Month MARCH Day 12 Year 2001

3. Time of Death: 7:20 PM

4a. Facility Name (If not institution, give street and number): DEATON Speciality Hospital & Home

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

**Funeral Director**

5. Social Security Number: 245-24-0039

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 75 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Mar 23, 1925

9. Birthplace (State or Foreign Country): North Carolina

Usual Residance of Decedant

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Wheaton

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 11926 Centerhill Street

10f. Zip Code: 20906

10g. Citizen of What Country?: USA

11. Maritel Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Dates: 1943-1945

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yas 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highast grada completed): Elamantary/Secondary (0-12): 12; Collega (1-4or 5+):

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired): Bus Driver

16b. Kind of Business/Industry: Public Transportation

17. Fether's Neme (First, Middla, Last): William Wayne Hodge

18. Mother's Name (First, Middle, Maiden Sumema): Leora Wright

19a. Informant'a Name/Relationship (Type, Print): Edith J. Hodge/ Wife

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code): 11926 Centerhill Street, Wheaton, MD 20902

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Nama of cemetary, cramatory or othar place): Gate of Heaven Cemetery; Date: Mar 17 2001

20c. Location - City or Town, State: Silver Spring, MD

21. Signeture of Funeral Service Licensee: John E. Parker

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complicetions that ceused the death. Do not enter tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each lina.

Approximate Interval Batwean Onset end Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiac arrythamia — 30 minutes

Due to (or as a consequence of):
b. Athorsclorotic Coronary artorial disease — 15+5

Sequentially list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Diabetes mellitus — 11

Due to (or as a consequence of):
d.

Part II. Othar significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic renal failure on hemodialysis

Decubitus ulcers

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performad? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was cese raterred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only ona): Hospital: 1 [✓] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accidant 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] Certifying Physician: To the best of my knowledga, daath occurred at the time, date and place, and due to tha cause(s) and manner as stated. 2 [ ] Medical Examinar: On the basis of examination and/or investigation, in my opinion, daath occurrad at tha time, data and place, and due to the cause(s) and manner stated.

29b. Signatura and title of certifier:

29c. License number: D30494

29d. Date signed (Month, Day, Year): 3/12/2001

30. Name and address of person who completed ceuse of daath (Item 23a) (Type, Print): Kristin Deaton Medical Center 611 South Charles St Baltimore MD 21230

**State Registrar**

31. Date filed (Month, Day, Year): MAR 14 2001

32. Registrar's Signature: Barbara B. Sparks

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0020**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

RILEY HODGE 6F

10

DHMH 16 Rev 6/95

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09376

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Hugh Hill

2. Date of Death (Month, Day, Year): March 8, 2001

3. Time of Death: 0610

4a. Facility Name (If not institution, give street and number): 4305 Rockport Lane

4b. City, Town, or Location of Death: Bowie

4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 578-60-6558

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 61 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): Sept. 27, 1939

9. Birthplace (State or Foreign Country): North. Ireland

Usual Residence of Decedent

10a. Stete: MD

10b. County: Prince George's

10c. City, Town or Location: Bowie

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 4305 Rockport Lane

10f. Zip Code: 20720

10g. Citizen of What Country?: Ireland

11. Meritel Stetus: 1 [ ] Never Merried 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Bleck, White, atc. Specify: White

15. Decedent's Education (Specify only highast grade completed)

Elementary/Secondery (0-12): 12

College (1-4or 5+):

16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired): Salesman

16b. Kind of Business/Industry: Carpet/Tile

17. Father's Nema (First, Middle, Last): Stanley Hill

18. Mother's Neme (First, Middle, Maiden Surnema): Rose Jackson

19a. Informent's Neme/Reletionship (Type, Print): (daughter) Mrs. Lisa Lynne Carpenter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 5538 Franklin Blvd., Churchton, MD 20733

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cramation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Piece of Disposition (Name of cemetary, cremetory or other place): Metropolitan Crematory

Dete: 3/10/01

20c. Location - City or Town, Stete: Alexandria, VA

21. Signature of Funeral Service Licensee: Robert Ramsey

22. Name and Address of Facility: Francis J. Collins Funeral Home 20901
500 University Blvd West, Silver Spring, MD

**Physician /Medical Examiner**

23a. Part1. Enter the diseesa, or complications thet caused tha death. Do not entar the mode of dying, such as cardiac or raspiratory arrast, shock, or heart feilura. List only one ceuse on each line.

Approximate Intarval Between Onset and Death

Immediate Cause (Finel diseese or condition resulting in deeth): a. Arteriosclerotic Heart Disease

Due to (or as a consequence of):

Sequentielly list conditions, if any, leeding to immediate cause. Entar Underlying Cause (Disaese or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [✓] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [✓] Yes 2 [ ] No

26. Place of Deeth (Check only one)

Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Horna 5 [✓] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Pleca of Injury - At horna, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred et the time, date and place, end due to tha cause(s) and menner es stated. 2 [✓] **Medical Examiner**: On tha basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and menner stated.

29b. Signatura and title of certifier: Salvador Ghetter, DO

29c. License number: H00557?

29d. Data signed (Month, Dey, Year): March 10, 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Salvador Ghetter 3001 Hospital Drive, Cheverly, Maryland 20785

**State Registrar**

31. Date filed (Month, Dey, Year): MAR 14 2001

32. Registrer's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09377

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): RETA HEUMAN
2. Date of Death (Month, Day, Year): MARCH 9, 2001
3. Time of Death: 1:40 PM
4a. Facility Name (If not institution, give street and number): Hebrew Home
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

**Funeral Director**

5. Social Security Number: 577-84-4537
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 99 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOV 7, 1901
9. Birthplace (State or Foreign Country): GERMANY

Usual Residence of Decedent

10a. State:
10b. County:
10c. City, Town or Location: WASHINGTON, D.C.
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4200 CATHEDRAL AVENUE, NW #910
10f. Zip Code: 20016
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): EMILE BAUER
18. Mother's Name (First, Middle, Maiden Surname): RICCA "UNKNOWN"

19a. Informant's Name/Relationship (Type, Print): SKIP WEST/GRANDSON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 800 NORTH LATHAM ST, ARLINGTON, VIRGINIA 22304

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MT. LEBANON CEMETERY
Date: MAR 11, 2001
20c. Location - City or Town, State: ADELPHI, MARYLAND

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Myocardial Infarction | 1 day |
| Due to (or as a consequence of): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. | |
| Due to (or as a consequence of): | | |
| | c. | |
| Due to (or as a consequence of): | | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic Renal Failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Gregory A Compton MD
29c. License number: D24942
29d. Date signed (Month, Day, Year): MAR 09 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GREGORY A. COMPTON, MD 5121 Montrose Rd Rockville MD

**State Registrar**

31. Date filed (Month, Day, Year): MAR 14 2001
32. Registrar's Signature: Barbara B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09378

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): HARRY HELLER
2. Date of Death (Month - Day - Year): 03 - 06 - 2001
3. Time of Death: 6:40pm
4a. Facility Name (If not institution, give street and number): MARINER HEALTH OF BETHESDA
4b. City, Town, or Location of Death: BETHESDA
4c. County of Death: MONTGOMERY

**Funeral Director**

5. Social Security Number: 577-58-6439
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): February 6, 1909
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 7616 Hamilton Spring Road
10f. Zip Code: 20817
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yaar or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highest grada completed): Elementary/Secondary (0-12): | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Attorney
16b. Kind of Business/Industry: Partner-Law Firm

17. Father's Name (First, Middle, Last): Nathan Heller
18. Mother's Name (First, Middle, Maiden Surname): Lottie Belsky

19a. Informant's Name/Relationship (Type, Print): Judith Zangwill / Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7616 Hamilton Spring Rd., Bethesda, MD 20817

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): King David Memorial Gardens | Date: 03/09/01
20c. Location - City or Town, State: Falls Church, VA

21. Signature of Funaral Sarvice Licensaa: Donald C. Stottlemyer
22. Name and Address of Facility: Danzansky Goldberg Memorial Chapel, Inc. 1170 Rockville Pike, Rockville, MD 20852

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. | Approximata Intarval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. ACUTE CARDIAC ARREST

Due to (or as a consequence of):
b. SEPSIS

Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. DILATED CARDIOMYOPATHY

Due to (or as a consequence of):
d. CONGESTIVE HEART FAILURE

Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case ratarred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28a. Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the tima, date and place, and due to tha cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha tima, data and place, and dua to the cause(s) and manner stated.

29b. Signature and title of certifier: Attan Kasid M.D., Ph.D.
29c. License number: D55054
29d. Data signed (Month, Day, Year): MARCH 6, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ATTAN KASID 17519 REDLAND ROAD ROCKVILLE

**State Registrar**

31. Date filed (Month, Day, Year): MAR 13 2001
32. Registrar's Signatura: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

6

10

ADH
ROBERT HELD
01-1363-031

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM 23a,ptII,27,28a-f per ME G794 041001 SS

# Certificate of Death

Reg. No. 2001 09379

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Robert W. Held, Jr.

2. Date of Death: Month MARCH Day 10, Year 2001

3. Time of Death: 0548 A M

4a. Facility Name (If not institution, give street and number): SUBURBAN HOSPITAL

4b. City, Town, or Location of Death: BETHESDA

4c. County of Death: MONTGOMERY

**Funeral Director**

5. Social Security Number: 297-34-3167

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 61 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb 28, 1940

9. Birthplace (State or Foreign Country): Ohio

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Bethesda

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 4853 Cordell Ave, #712

10f. Zip Code: 20814

10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: Unknown

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Communications

18b. Kind of Business/Industry: U.S. Navy

17. Father's Name (First, Middle, Last): Robert W. Held

18. Mother's Name (First, Middle, Maiden Surname): Elinor J. McGookey

19a. Informant's Name/Relationship (Type, Print): James A. Held/Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1325 Alderton Ln, Silver Spring, MD 20906

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Fort Lincoln Crematory

Date: Mar 14

20c. Location - City or Town, State: Brentwood, MD

21. Signature of Funeral Service Licensee: Alan J. Darnell

22. Name and Address of Facility: Hines-Rinaldi Funeral Home
11800 New Hampshire Ave, Silver Spring, MD 20904

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. HEAD INJURIES COMPLICATED BY ACUTE ETHANOL INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSIVE CARDIOVASCULAR DISEASE

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

28. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year) found: 3-10-01

28b. Time of Injury found: 5:20 A M

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: subject was intoxicated and fell

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): found: residence

28f. Location (Street and Number or Rural Route Number, City or Town, State): 4853 Cordell Avenue, Bethesda, MD

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.

29c. License number: OCME

29d. Date signed (Month, Day, Year): MARCH 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mary C. Ripple, M.D. 111 Penn Street, Baltimore, Maryland 21201

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**State Registrar**

31. Date filed (Month, Day, Year): MAR 15 2001

32. Registrar's Signature: [signature] B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09380

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Dorothy L. Hampton

2. Date of Death: Month March, Day 15, Year 2001

3. Time of Death: 12:30 AM

4a. Facility Name (If not institution, give street and number): Manor Care- Bethesda

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 219-54-6988

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 95 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): January 18, 1906

9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Potomac

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 10121 Counselman Road

10f. Zip Code: 20854

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Henry Latterner

18. Mother's Name (First, Middle, Maiden Surname): Letitia Daw

19a. Informant's Name/Relationship (Type, Print): Richard T. Hampton/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1390 Canterbury Way, Rockville, Maryland 20854

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Rock Creek Cemetery

Date: March 19 2001

20c. Location - City or Town, State: Washington, D.C.

21. Signature of Funeral Service License: David E. Perry. M00803

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Atrial Fibrillation

Due to (or as a consequence of):

c. Atherosclerosis

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular Accident

Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robert MD

29c. License number: D31319

29d. Date signed (Month, Day, Year): March 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Loreto Albiol, M.D. 8218 Wisconsin Avenue, #103, Bethesda, Maryland 20814

**State Registrar**

31. Date filed (Month, Day, Year): MAR 16 2001

32. Registrar's Signature: Linda B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

RKD

01-1281-031

DESTINY
IRONDI

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM 23a,27 per ME G794 04110I SS

# Certificate of Death

Reg. No. 2001 09381

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Destiny Nwamara Irondi

2. Date of Death: Month MARCH Day 7, Year 2001

3. Time of Death: 6:51P. M

4a. Facility Name (If not institution, give street and number): WASHINGTON ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: TAKOMA PARK

4c. County of Death: MONTGOMERY

**Funeral Director**

5. Social Security Number: 213-55-7686

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 1 Yrs.

If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 12, 1999

9. Birthplace (State or Foreign Country): Maryland

Usuet Residence of Decedent

10a. State: Md

10b. County: Prince Georges

10c. City, Town or Location: Hyattsville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4009 Gallatin Street, Apt. T-2

10f. Zip Code: 20781

10g. Citizen of Whet Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indien, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 0; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): N/A

16b. Kind of Business/Industry: N/A

17. Father's Name (First, Middle, Last): Donald E. Irondi

18. Mother's Name (First, Middle, Maiden Surname): April C. Irondi

19a. Informant's Name/Relationship (Type, Print): April C. Irondi/Mother

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 4009 Gallatin Street, Apt T-2 Hyattsville, Md 20781

20a. Method of Disposition: 1☒ Buriat 2☐ Cremation 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)

20b. Piece of Disposition (Name of cemetery, cremetory or other place): Harmony Memorial Park Date: 03/13/2001

20c. Location - City or Town, Steta: Landover, Maryland

21. Signature of Funeral Service Licensee: ▶ Joanne E. Allsberry

22. Name and Address of Facility: McGuire Funeral Service, Inc. 7400 Georgia Avenue, N.W. Wash., D.C. 20012

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0036**

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. GASTROENTEROCOLITIS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Dey Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

**Medical Certification; To Be Completed by Physician/Medical Examiner**

25. Wes case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifyng Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es stated. 2☒ **Medicat Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to tha cause(s) end manner stated.

29b. Signature and title of certifier: ▶ J Pestaner, M.D.

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Yaer): MARCH 8,2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Division of Vital Records, P.O. Box 68760,**

**State Registrar**

31. Date filed (Month, Day, Year): MAR 13 2001

32. Registrar's Signature: ▶ Denise B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 09382

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Agnes Marie Johnson

2. Data of Death Month Day Yaar: March 10, 2001

3. Tima of Death: 8:30 AM

4a. Facility Nama *(If not institution, giva street and number)*: Potomac Valley Nursing Center

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

**Funeral Director**

5. Social Sacurity Number: 579-40-3177

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 91 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: June 10, 1909

9. Birthplaca *(State or Foreign Country)*: Pennsylvania

**To Be Completed by Funeral Director**

Usual Residance of Decedant

10a. Stata: Maryland

10b. County: Montgomery

10c. City, Town or Location: Washington Grove

10d. Insida City Limits: 1☐ Yas 2☒ No

10e. Street and Numbar: 409 5th Avenue

10f. Zip Coda: 20880

10g. Citizan of What Country?: United States

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No. If Yas, Giva Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.): 1☐ Yas 2☒ No *Specify:*

14. Race - American Indian, Black, White, atc. *Specify:* White

15. Decedant's Education *(Specify only highast grada complatad)*: Elamentary/Secondary (0-12): Collaga (1-4or 5+): 5+

16a. Decedant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratirad)*: Housewife

16b. Kind of Businass/Industry: Own Home

17. Fathar's Nama *(First, Middla, Last)*: Charles Henry McMullen

18. Mothar's Nama *(First, Middla, Maidan Surnama)*: Annie VonWinkle

19a. Informant's Name/Ralationship *(Type, Print)*: Carol A. Gomez, Niece

19b. Mailing Addrass *(Street and Numbar or Rural Routa Numbar, City or Town, Stata, Zip Coda)*: P. O. Box 1109, Bethany Beach, Delaware 19930

20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Placa of Disposition *(Nama of camatary, cramatory or othar placa)*: Metropolitan Crematory

Data: March 11 2001

20c. Location - City or Town, Stata: Alexandria, Virginia

21. Signatura of Funaral Sarvica Licansaa: [signature]

22. Nama and Addrass of Facility: DeVol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD 20877

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Entar the diseasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only ona causa on aach lina.

Approximata Intarval Batwaan Onset and Death

Immediata Causa (Final disaasa or condition rasulting in death)

a. Coronary artery disease — years

Dua to (or as a consaquanca of):

b. Chronic obstructive lung disease — years

Saquantially list conditions, if any, laading to immadiata cause. Entar Undarlying Causa (Disaasa or injury that initiatad avants rasulting in daath) Last

Dua to (or as a consaquanca of):

c. Dementia. — years

Dua to (or as a consaquanca of):

d.

Part II. **Other significant conditions** contributing to daath but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Ware autopsy findings availabla prior to complation of cause of daath? 1☐ Yas 2☒ No

25. Was casa rafarrad to medical examinar? 1☐ Yas 2☒ No

26. Placa of Death *(Check only ona)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA; Othar: 4☒ Nursing Homa 5☐ Rasidanca 6☐ Othar *(Specify)*

27. Mannar of Daath: 1☒ Natural 2☐ Accidant 3☐ Sulcida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarminad

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurrad

28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. *(Spacify)*

28f. Location *(Straat and Numbar or Rural Routa Numbar, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☐ **Certifying Phyaician:** To tha best of my knowladga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as statad. 2☐ **Medical Examinar:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha cause(s) and mannar statad.

29b. Signatura and title of cartifiar: [signature]

29c. Licansa number: D 50987

29d. Data signed *(Month, Day, Year)*: 3-10-01.

30. Nama and addrass of parson who complatad causa of daath (Item 23a) (Type, Print): AHMED NAWAR 1299 Lamberton drive Silver Spring MD 20902.

**State Registrar**

31. Data filed *(Month, Day, Year)*: MAR 12 2001

32. Registrar's Signatura: [signature] B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

20

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09383

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Rose Tuett

2. Date of Death — Month: March Day: 7th Year: 2001

3. Time of Death: 7.50A

4a. Facility Name (If not institution, give street and number): Deer's Head Center

4b. City, Town, or Location of Death: Salisbury

4c. County of Death: Wicomico

**Funeral Director**

5. Social Security Number: 401-48-5090

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 64 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): December 3, 1936

9. Birthplace (State or Foreign Country): Kentucky

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland

10b. County: Dorchester

10c. City, Town or Location: Hurlock

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4004 Bradley Circle

10f. Zip Code: 21643

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 9

College (1-4or 5+): –

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cashier/Manager

16b. Kind of Business/Industry: Restaurant

17. Father's Name (First, Middle, Last): Edward Wiggins

18. Mother's Name (First, Middle, Maiden Surname): Ida Elizabeth Small

19a. Informant's Name/Relationship (Type, Print): Diana Wilson/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4004 Bradley Circle, Hurlock, MD 21643

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Olive Branch Cemetery

Date: 3/10/01

20c. Location - City or Town, State: Portsmouth, VA

21. Signature of Funeral Service Licensee: John M. Holloway

22. Name and Address of Facility: Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia — 1 month

Due to (or as a consequence of):

b. SP. Respiratory failure with tracheostomy — 4 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Pulmonary Embolism and recurrent Pneumonia — 4 months

Due to (or as a consequence of):

d. Cerebellar Mass Surrounding fourth Ventricle. inoperable site.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Abdominal wound dehescence with gastric fistula.

Diabetes Mellitus type 2

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M. Shrestha M.D.

29c. License number: D.0016278

29d. Date signed (Month, Day, Year): March 7th 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Deer's Head Center. P.O.Box 2018 Salisbury Md 21802-2018

**State Registrar**

31. Date filed (Month, Day, Year): MAR 13 2001

32. Registrar's Signature: Geneva B Sparks

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6 DQ

DHMH 16 Rev 6/95

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 09384

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): PHILOMENA M JENKINS

2. Date of Death (Month, Day, Year): MARCH 10, 2001

3. Time of Death: 8:04 AM

4a. Facility Name (If not institution, give street and number): WASHINGTON ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: TAKOMA PARK

4c. County of Death: MONTGOMERY

**Funeral Director**

5. Social Security Number: 577-20-8982

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JANUARY 16, 1922

9. Birthplace (State or Foreign Country): WASHINGTON, D.C

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: PRINCE GEORGES

10c. City, Town or Location: COLLEGE PARK

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 9014 RHODE ISLAND AVENUE #712

10f. Zip Code: 20740

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CASHIER

16b. Kind of Business/Industry: RETAIL

17. Father's Name (First, Middle, Last): ROCCO DONATIELLO

18. Mother's Name (First, Middle, Maiden Surname): MARIA PORECCA

19a. Informant's Name/Relationship (Type, Print): RUTH FOSTER / NIECE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8215 16TH AVENUE, ADELPHI MARYLAND 20783

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): FORT LINCOLN CEMETERY

Date: 3-15-01

20c. Location - City or Town, State: BRENTWOOD, MARYLAND

21. Signature of Funeral Service Licensee: Raion Patterson

22. Name and Address of Facility: HINES-RINALDI FH 20904

11800 NEW HAMPSHIRE AVENUE, SILVER SPRING MD

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure — 4 yrs

Due to (or as a consequence of):

b. Coronary Heart Disease — 4 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part ff. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Part I.

23b. Dfd tobacco use contributs to the causs of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☑ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☑ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: H. Walter

29c. License number: D07850

29d. Date signed (Month, Day, Year): 3/10/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): H. WALTER, 7610 Connell Lane, Takoma Park, MD

**State Registrar**

31. Date filed (Month, Day, Year): MAR 15 2001

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.** 6

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

8

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09385

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ELAINE JARVIS
2. Date of Death (Month, Day, Year): MARCH 12, 2001
3. Time of Death: 9:15 PM
4a. Facility Name (If not institution, give street and number): SUBURBAN HOSPITAL
4b. City, Town, or Location of Death: BETHESDA
4c. County of Death: MONTGOMERY

**Funeral Director**

5. Social Security Number: 134.28.4894
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 63 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JUNE 18, 1937
9. Birthplace (State or Foreign Country): NEW YORK

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: MONTGOMERY
10c. City, Town or Location: CHEVY CHASE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 5500 FRIENDSHIP BLVD #2126N
10f. Zip Code: 20815
10g. Citizen of What Country?: USA
11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CONSUMER BANKER
16b. Kind of Business/Industry: BANKING
17. Father's Name (First, Middle, Last): LEO ULLMANN
18. Mother's Name (First, Middle, Maiden Surname): BERTHA FELSENTHAL
19a. Informant's Name/Relationship (Type, Print): LINDA SMOLKIN/DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4305 LYNBROOK DRIVE, BETHESDA, MARYLAND 20814
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): JUDEAN MEMORIAL GARDENS
Date: MARCH 14, 2001
20c. Location - City or Town, State: OLNEY, MARYLAND
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cerebral hemorrhage — days

Due to (or as a consequence of):
b. Brain tumor — months-yrs.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: William F. Simonds, MD
29c. License number: D36520
29d. Date signed (Month, Day, Year): March 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William F. Simonds, M.D., Suburban Hospital, Dept. of Medical Education

**State Registrar**

31. Date filed (Month, Day, Year): MAR 16 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed/filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

JARVIS, ELAINE 3/12/01 9:15 PM

**Medical Certification: To Be Completed by Physician/Medical Examiner**

6

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 09386

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Emmanuel C. Jackson
2. Date of Death (Month, Day, Year): March 11, 2001
3. Time of Death: 5:52 A.M.
4a. Facility Name *(If not institution, give street and number)*: Southern M.D. Hospital
4b. City, Town, or Location of Death: Clinton
4c. County of Death: P.G.

**Funeral Director**

5. Social Security Number: 578-70-2469
6. Sex: 1☐M 2☐F — 1☒
7. Age *(In yrs. last birthday)*: 46yrs. Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 7- 24-1954
9. Birthplace *(State or Foreign Country)*: Wash. DC

Usual Residence of Decedent

10a. State: MD
10b. County: P.G.
10c. City, Town or Location: Upper Marlboro
10d. Inside City Limits: 1☐Yes 2☐No — 1☒
10e. Street and Number: 4410 Dery Road
10f. Zip Code: 20772
10g. Citizen of What Country?: U.S.

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sheet Metal Mechanic
16b. Kind of Business/Industry: Kojok Construction

17. Father's Name *(First, Middle, Last)*: Norris C. Jackson
18. Mother's Name *(First, Middle, Maiden Surname)*: Shirley M. Gilbert

19a. Informant's Name/Relationship *(Type, Print)*: Emmanuel C. Leach (son)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 316 19th St. N.E. Wash. DC 20002

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Olivet Cemetery
Date: 3-21-01
20c. Location - City or Town, State: Wash. DC

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Austin Royster Funeral Home 3821 14th Street, N W, Wash DC

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cerebrovascular Accident
Due to (or as a consequence of):
b. Intracranial Hemorrhage
Due to (or as a consequence of):
c. Hypertension
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: End stage Renal Disease

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death *(Check only one)*: Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 8☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MS
29c. License number: D53885
29d. Date signed *(Month, Day, Year)*: 3-12-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Venkat S. Ramanan 7501 Surratus Rd. #307 Clinton MD 20735

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 15 2001
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

3

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09387

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Martha Virginia Kehne

2. Date of Death (Month, Day, Year): March 10, 2001

3. Time of Death: 12:15pm

4a. Facility Name (If not institution, give street and number): 5307 Mussetter Road

4b. City, Town, or Location of Death: Ijamsville

4c. County of Death: Frederick

**Funeral Director**

5. Social Security Number: 218-32-8214

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 90 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb 20, 1911

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Ijamsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 5307 Mussetter Road

10f. Zip Code: 21754

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Grover C Dixon

18. Mother's Name (First, Middle, Maiden Surname): Adella Bussard

19a. Informant's Name/Relationship (Type, Print): Doris K. Fields/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14021 Old Hanover Road, Reisterstown MD 21136

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt Olivet Cemetery

Date: Mar 14, 2001

20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: Kathryn R. Berson M00706

22. Name and Address of Facility: Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Coronary Artery Disease — Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D36649

29d. Date signed (Month, Day, Year): March 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Edward P. Riuli, M.D., 180 Thomas Johnson Drive, #202, Frederick, Maryland 21702

**State Registrar**

31. Date filed (Month, Day, Year): MAR 13 2001

32. Registrar's Signature: [signature]

ORIGINAL

DHMH 16 Rev 6/95

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Amended item#23(b) per MD FCHD 3/16/01

Reg. No. 2001 09388

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|
| BENJAMIN | KOENIG | MARCH 12, 2001 | 8:25 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 11909 LYNN CREST DRIVE | MONROVIA | FREDERICK |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 718-14-9501 | 1☒ M 2☐ F | 89 Yrs. | | | 11/10/1911 | Washington, DC |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Frederick | Monrovia | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 11909 Lynn Crest Drive | 21770 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 4 | | Supervisor | Railroad |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| John Clifton Koenig | Etta Gertrude Smoot |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Betty L. Koenig-wife | 11909 Lynn Crest Drive Monrovia, MD 21770 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | FT. LINCOLN | 3/16/2001 | Brenton, MD |

21a. Signature of Funeral Service Licensee ▶ Ralph B. MacKay

22. Name and Address of Facility
STAUFFER FUNERAL HOMES, P.A.
1621 OPOSSUMTOWN PIKE, FREDERICK, MD 21702

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. respiratory failure | weeks |
| | Due to (or as a consequence of): Chronic obstructive lung disease | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

congestive heart failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☑ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☑ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☐ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ | 20148 | March 13, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Steven Dolinsky MD 911 Russell Ave, Gaithersburg MD

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 15 2001 | ▶ Donna B Spark |

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 09389

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Frank J. Kreysa

2. Date of Death Month Day Year: March 12, 2001

3. Time of Death: 1:20 AM

4a. Facility Name *(If not institution, give street and number)*: SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

**Funeral Director**

5. Social Security Number: 098-12-3092

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 21, 1919

9. Birthplace *(State or Foreign Country)*: Czech Republic

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Gaithersburg

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 419 Russell Avenue, #409

10f. Zip Code: 20877

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) | College (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Chief Scientist

16b. Kind of Business/Industry: Federal Government

17. Father's Name *(First, Middle, Last)*: Francis J. Kreysa

18. Mother's Name *(First, Middle, Maiden Surname)*: Marie Koukl

19a. Informant's Name/Relationship *(Type, Print)*: Aida Kreysa/Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 419 Russell Avenue, #409, Gaithersburg, MD 20877

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Resthaven Cemetery

Date: March 16, 2001

20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: ▶ Will E Bowen Jr. M00672

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode ot dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)

a. Septic Shock

Due to (or as a consequence ot):

b. Pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Renal Insufficiency

Atrial Flutter

Hypoalbunemia

23b. Did tobacco use contribute to the causa of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: ▶ Joseph A Ball MD

29c. License number: 53317

29d. Date signed *(Month, Day, Year)*: March 12 2001

30. Neme and address of person who completed ceuse of death (Item 23a) (Type, Print): Joseph A Ball 16220 Frederick Road Suite 213 Gaithersburg MD 20877

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 16 2001

32. Registrar's Signature: ▶ Donna B. Sparks

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

b

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

14

**Medical Certification: To Be Completed by Physician/Medical Examiner**

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09390

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): EMMA KRAFT
2. Date of Death: Month MARCH Day 10 Year 2001
3. Time of Death: 18:30
4a. Facility Name (If not institution, give street and number): Howard County Hospital
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

**Funeral Director**

5. Social Security Number: 155-24-5040
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 16, 1910
9. Birthplace (State or Foreign Country): Germany

Usual Residence of Decedent

10a. State: N.J.
10b. County: Union
10c. City, Town or Location: Summit
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2 Ashwood Court
10f. Zip Code: 07901
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): Unknown; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Unknown
18. Mother's Name (First, Middle, Maiden Surname): Unknown

19a. Informant's Name/Relationship (Type, Print): Walter Kraft - Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2 Ashwood Ct. Summit, NJ 07910

20a. Method of Disposition: ☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hollywood Memorial Park
Date: 3/15/01
20c. Location - City or Town, State: Union, NJ

21. Signature of Funeral Service Licensee: ▶ Dennis A. Pittman
22. Name and Address of Facility: Metropolitan Funeral Service 5517 Vine Street. Alexandria, VA 22310

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CARDIAC ARREST — DAY OF DEATH

Due to (or as a consequence of):
b. ATHEROSCLEROSIS — YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. DEMENTIA — YEARS

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ H A Oken MD
29c. License number: D31172
29d. Date signed (Month, Day, Year): March 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): H. A. OKEN 3400 Ellicott Center Dr. Suite 103 Ellicott City MD 21043

**State Registrar**

31. Date filed (Month, Day, Year): MAR 14 2001
32. Registrar's Signature: ▶ Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No: 2001 09391

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Connie Lee Kooser | March 11, 2001 | 9:52 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Frederick Memorial Hospital | Frederick | Frederick |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 179-28-3314 | 1☐M 2☒F | 65 Yrs. | | | Aug 27, 1935 | Brownfield, PA |

**Usual Residence of Decedent**

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| WV | Jefferson | Harpers Ferry | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| Route # 1 Box 1214 | 25425 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) | 14. Rece - American Indian, Bleck, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Clarence Baker | Annabelle Lewis |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Ronald W. Kooser | Rt. #1 Box 1214 Harpers Ferry, WV 25425 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Mt. View Cemetery | March 15, 01 | Brownfiled, PA |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Dennis A. Pettinger | Capital Funeral service 7211 Lee Hwy, Falls Church, VA 22046 |

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE EXACERBATION OF CHRONIC OBSTRUCTIVE PULMONARY DISEASE — Approximate Interval Between Onset and Death: 3 DAYS

Due to (or as a consequence of):

b. ASPIRATION PNEUMONIA — 3 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. PROLONGED CEREBRAL HYPOXIA — 3DAYS

Due to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnency 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobecco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☒Yes 2☐No 3☐Probably 4☐Unknown | 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Dete signed (Month, Day, Year) |
|---|---|---|
| ▶ Neil Warnavskian MD | D47611 | March 11, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
NEIL WARNAVSKIAN MD 1475 TANEY AVE # 204 FREDERICK MD 21702

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 14 2001 | Jeanne B. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 09392

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Rosalie E. Klompus

2. Date of Death Month Day Year: March 5, 2001

3. Time of Death: 1:22 P M

4a. Facility Name (If not institution, give street and number): Shady Grove Adventist Hospital

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 214-14-4338

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 80 Yrs.

If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 19, 1920

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 299 Hurley Avenue

10f. Zip Code: 20850

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Years; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Abraham Ehrlich

18. Mother's Name (First, Middle, Maiden Surname): Esther Shapiro

19a. Informant's Name/Relationship (Type, Print): Leonard L. Klompus - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3950 Kalai Waa Dr., E 103, Wailea Maui, HI 96753

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Hebrew Youne Men's Cem. Date: 3/7/2001

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Donald C. Stottlemyer

22. Name and Address of Facility: DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Multisystem Organ Failure — 2 DAys

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Septic Shock — 2 Days

Due to (or as a consequence of):
c. Pneumonia — 2 Days

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Valvular Heart Disease

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Virendra Saxena

29c. License number: D30112

29d. Date signed (Month, Day, Year): March 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Virendra K. Saxena, M. D. 15000 Muirfield Drive, Potomac, Maryland 20854

**State Registrar**

31. Date filed (Month, Day, Year): MAR 13 2001

32. Registrar's Signature: Bruce B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09393

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Dr. Joseph Klements
2. Date of Death (Month, Day, Year): March 10, 2001
3. Time of Death: 8:15 AM
4a. Facility Name (If not institution, give street and number): Brighton Gardens
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 065-18-0414
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 88 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 30, 1912
9. Birthplace (State or Foreign Country): Germany

Usual Residence of Decedant

10a. State: Florida
10b. County: Broward
10c. City, Town or Location: Pompano Beach
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4106 Palmaire Dr. West
10f. Zip Code: 33069
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1943-46
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): Collega (1-4or 5+): 5 +
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Physician
16b. Kind of Business/Industry: Medical

17. Father's Name (First, Middle, Last): David Klementinovski
18. Mother's Name (First, Middle, Maiden Surname): Helene Schwabsky

19a. Informant's Name/Relationship (Type, Print): Newton L. Klements - Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11001 Wickshire Way Rockville, MD. 20852

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): Star of David Mem. Gards.
Date: 3/12/01
20c. Location - City or Town, State: North Lauderdale, FL.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike Rockville, MD. 20852

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiopulmonary Arrest — 15 Mins.

Due to (or as a consequence of):
b. Arteriosclerotic Heart Disease — 6 Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Cerebral Arteriosclerosis
Renal Insufficiency

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)
1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Henry Roth MD
29c. License number: D09946
29d. Date signed (Month, Day, Year): March 10, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Henry Roth, M.D. 1801 E. Jefferson St. Rockville, MD. 20852

**State Registrar**

31. Date filed (Month, Day, Year): MAR 13 2001
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

18

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09394

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Lin Won Kim
2. Date of Death: Month March, Day 13, Year 2001
3. Time of Death: 9:30 AM
4a. Facility Name (If not institution, give street and number): Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 230-21-9212
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): December 21, 1923
9. Birthplace (State or Foreign Country): Korea

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 3227 Hewitt Avenue, Apartment 103
10f. Zip Code: 20906
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Asian

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Technician
16b. Kind of Business/Industry: Business Machines

17. Father's Name (First, Middle, Last): Dae Kim
18. Mother's Name (First, Middle, Maiden Surname): (Unobtainable) Lee

19a. Informant's Name/Relationship (Type, Print): Mr. Dennis Kim / Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11304 Castlewood Ct. Laurel, MD 20723

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Ft. Lincoln Crematory
Date: 3/16/01
20c. Location - City or Town, State: Bladensburg, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave Silver Spring, MD 20904

**Physician /Medical Examiner**

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Acute MI

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. ASCVD
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. Licensa number: D24348
29d. Date signed (Month, Day, Year): 3.13.01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Steven Grufferman MD 1500 Forest Glen Rd. Silver Spring, MD 20910

**State Registrar**

31. Date filed (Month, Day, Year): MAR 15 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09395

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): LiBby KASPAR
2. Date of Death: Month March Day 11 Year 2001
3. Time of Death: 4:30pm
4a. Facility Name (If not institution, give street and number): Esther's Place
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

**Funeral Director**

5. Social Security Number: 220-22-1817
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 94 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug 18, 1906
9. Birthplace (State or Foreign Country): Czechoslova

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10a. Street and Number: 830 N. Linwood Avenue
10f. Zip Code: 21205
10g. Citizen of What Country?: United States
11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detea:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 5 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Seamstress
16b. Kind of Business/Industry: Clothing
17. Father's Name (First, Middle, Last): Frank Miller
18. Mother's Name (First, Middle, Maiden Sumame): Anna Johanna Audolensky
19a. Informant's Name/Relationship (Type, Print): Jerome Kaspar /Step-son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 830 N. Linwood Avenue, Baltimore, MD 21205
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory
Date: Mar 12 2001
20c. Location - City or Town, State: Beltsville, MD
21. Signature of Funeral Service Licensee: [signature] M00984
22. Name and Address of Facility: Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, MD

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Mixed Mullerian Mesodermal Tumor — 1 yr.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last:
b. Due to (or as e consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☒ Other (Specify) assisted living

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(a) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D04383
29d. Date signed (Month, Day, Year): 3/12/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W.J. Greenough II, MD 5505 Hopkins Bayview Circle 21287 MD 21224

**State Registrar**

31. Date filed (Month, Day, Year): MAR 13 2001
32. Registrar's Signature: [signature] S. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

6

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 09396

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Joseph Frederick Kalbacher
2. Date of Death Month Day Year: March 5, 2001
3. Time of Death: 5:30am
4a. Facility Name *(If not institution, give street end number)*: 6901 Tilden Lane
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 110-20-3410
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 73 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 15, 1927
9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 6901 Tilden Lane
10f. Zip Code: 20852
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1944-46
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12); College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Certified Public Accountant
16b. Kind of Business/Industry: Accounting Firm

17. Father's Name *(First, Middle, Last)*: Joseph Frederick Kalbacher
18. Mother's Name *(First, Middle, Maiden Surname)*: Sadie Young

19a. Informant's Name/Relationship *(Type, Print)*: Catherine Kalbacher /Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6901 Tilden Lane, Rockville, MD 20852

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Crematory — Date: Mar 12 2001
20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: Beverly L Hewitt
22. Name and Address of Facility: Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, MD

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Congestive Heart Failure

Due to (or as a consequence of): b. Coronary Atherosclerosis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Allen P Burke
29c. License number: D32156
29d. Date signed *(Month, Day, Year)*: March 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Allen P. Burke M.D. 6825 16th St. NW, Washington, DC 20036

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 13 2001
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

---

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

6

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12+1

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09397

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Pauline Elizabeth Lusk

2. Date of Death (Month, Day, Year): March 11, 2001

3. Time of Death: 8:45 AM

4e. Facility Name (If not institution, give street and number): Montgomery Village Care & Rehabilitation

4b. City, Town, or Location of Death: Montgomery Village

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 577-24-8918

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 11, 1921

9. Birthplace (State or Foreign Country): Washington, D.C.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 417 Mercer Road

10f. Zip Code: 20852

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Nicholas Dominic Baron

18. Mother's Name (First, Middle, Maiden Surname): Ida Mae Miller

19a. Informant's Name/Relationship (Type, Print): Pamela M. Stone/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2543 Lander Road, Jefferson, Maryland 21755

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc. | Date: March 12, 2001

20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: William E. Bowman Jr. M00672

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. acute myocardial infarction

Due to (or as a consequence of):
b. Coronary artery Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. Congestive Heart failure.

Due to (or as a consequence of):
d. Cerebro vascular accident.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension.

Atrial fibrillation.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: V. Ganti MD

29c. License number: D41162 MD

29d. Date signed (Month, Day, Year): March 11 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): V. Ganti MD 19529, Doctors Drive Germantown MD 20874

**State Registrar**

31. Date filed (Month, Day, Year): MAR 12 2001

32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

---

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

3/11/01 8:45A

Lusk

25

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Amend #28c, 3/12/2001, BMW, Montg.Co.

# Certificate of Death

Reg. No. 2001 09398

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Lorraine Lindsey Loyd

2. Date of Death: Month 03 Day 06 Year 2001

3. Time of Death: 11:59 pm

4a. Facility Name (If not institution, give street and number): University of Shock Trauma - Maryland Medical Ctr.

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore City

**Funeral Director**

5. Social Security Number: 578-20-5875

6. Sex: 1☐ M 2☑ F

7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 14, 1922

9. Birthplace (State or Foreign Country): DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Adelphi

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 8211 18th Avenue

10f. Zip Code: 20783

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Earl William Lindsey

18. Mother's Name (First, Middle, Maiden Surname): Elsa Gladding

19a. Informant's Name/Relationship (Type, Print): Donna Stamford/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8211 18th Avenue, Adelphi, MD 20783

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory | Date: March 10 2001

20c. Location - City or Town, State: Alexandria, VA

21. Signature of Funeral Service Licensee: Robert E Ramsey

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. SEPSIS

Due to (or as a consequence of):
b. Necrotizing Fasciitis of the Groin — 2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Geffen Davis MD PHYS

29c. License number: BATHMORE 8000

29d. Date signed (Month, Day, Year): March 7, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Geffen Davis, MD 22 South Greene St. Baltimore, MD 21201

31. Date filed (Month, Day, Year): MAR 12 2001

32. Registrar's Signature: G. Sparks

**State Registrar**

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Loyd

Lorraine

10

5

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09399

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Richard W. Littwin
2. Date of Death (Month, Day, Year): March 7, 2001
3. Time of Death: 4:47 pm
4a. Facility Name (If not institution, give street and number): Forest Glen Nursing & Rehab Center
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 579-24-5015
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 26, 1926
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Calvert
10c. City, Town or Location: Owings
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 2018 Boyds Trail
10f. Zip Code: 20736
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Operating Engineer
16b. Kind of Business/Industry: Union

17. Father's Name (First, Middle, Last): Victor Littwin
18. Mother's Name (First, Middle, Maiden Surname): Rebecca Armstrong

19a. Informant's Name/Relationship (Type, Print): Russell Littwin (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 419 Lincoln Street Rockville, MD 20850

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Old Leeds Cemetery
Date: 3/10/01
20c. Location - City or Town, State: Markham, Virginia

21. Signature of Funeral Service Licensee: Dennis C. Pittman
22. Name and Address of Facility: Metropolitan Funeral Service, Inc. 5517 Vine Street Alexandria, VA 22310

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Carcinoma of lung with metastasis — 6 mo

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in *my* opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Myron L. Lenkin MD
29c. License number: D0 6674
29d. Date signed (Month, Day, Year): 3/08/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MYRON L LENKIN MD 2309 SHORFIELD RD WHEATON, MD. 20902

**State Registrar**

31. Date filed (Month, Day, Year): MAR 12 2001
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09400

ROY LINK

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Roy Link
2. Date of Death (Month, Day, Year): March 5, 2001
3. Time of Death: 6:15 PM
4a. Facility Name (If not institution, give street and number): Mariner of Southern Maryland
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 154-14-0021
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 29, 1921
9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Brandywine
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 15711 Nelson Perrie Road
10f. Zip Code: 20613
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 9-11-42-1-21-46
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Rece - American Indian, Biack, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Stationary Engineer
16b. Kind of Business/Industry: Manufacturing

17. Father's Name (First, Middle, Last): Anton T. Link
18. Mother's Name (First, Middle, Maiden Surname): Theresa (Unknown)

19a. Informant's Name/Relationship (Type, Print): Jean Bone/Daughter
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15711 Nelson Perrie Rd., Brandywine, MD 20613

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removel from Stete 4 [ ] Donation 5 [ ] Other (Specify)
20b. Placa of Disposition (Name of cemetery, crematory or other place): Graceland Memorial Park
Date: 3/9/01
20c. Location - City or Town, State: Kenilworth, NJ

21. Signature of Funeral Service Licensee: Karen J. Waddell
22. Name and Address of Facility: Metropolitan Funeral Service, Inc 5517 Vine Street, Alexandria, VA 22310

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arreat, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. sepsis — days

Due to (or as a consequence of):
b. End Stage Renal disease — months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or aa a consequence of):
c. Anemia — weeks

Due to (or as a consequence of):
d.

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Part I.
Insulin dpendent diabetes melitus.

23b. Did tobacco uss contributs to the causa of death? 1 [ ] Yaa 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Menner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Placa of Injury - At home, farm, street, fectory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examinetion and/or investigation, In my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: Rointan Farahi M.D.
29c. License number: D43446
29d. Dale signed (Month, Day, Year): 3/6/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROINTAN FARAHI FAR 9801 Georgia Ave Suit 3-35 SILVER SPRING MD 20902

**State Registrar**

31. Date filed (Month, Day, Year): MAR 12 2001
32. Registrar's Signetura: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 09401

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): BERNARD LIBERMAN

2. Date of Death (Month, Day, Year): March 13, 2001

3. Time of Death: 11 PM

4a. Facility Name (If not institution, give street and number): HEBREW HOME OF GREATER WASHINGTON

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 028-09-6382

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 14, 1912

9. Birthplace (State or Foreign Country): Boston, MA

Usual Residence of Decedant

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 14633 Deerhurst Terrace

10f. Zip Code: 20906

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Educetion (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Buisness Man

16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): Nathan Liberman

18. Mother's Neme (First, Middle, Maiden Surname): Rose Liberman

19a. Informant's Name/Reletionship (Type, Print): Ruth R. Liberman-Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14633 Deerhurst Terrace, Silver Spring, MD 20906

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from State 4☐ Donetion 5☐ Othar (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Lebanon Cemetery

Date: 03/16/01

20c. Location - City or Town, State: Adelphia, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Pearson Funeral Home, 472 N. Washington St., Falls Church, VA 22046

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequance of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. CORONARY ARTERY DISEASE

Due to (or as a consequance of):

c.

Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Othar: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined

28a. Data of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.

29c. License number: D 18084

29d. Data signed (Month, Day, Year): MARCH 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): D. D. PATEL, M.D. 612, MONTROSE RD, ROCKVILLE MD 20852

**State Registrar**

31. Data filed (Month, Day, Year): MAR 16 2001

32. Registrar's Signature: [signature] B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 09402

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Mildred Pearlove Levin

2. Date of Death: Month March Day 14, Year 2001

3. Time of Death: 4:00P.

4a. Facility Name (If not institution, give street and number): 4701 Willard Avenue, #202

4b. City, Town, or Location of Death: Chevy Chase

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 473-14-4006

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Apr.26,1920

9. Birthplace (State or Foreign Country): Minnesota

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Chevy Chase

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4701 Willard Avenue, #202

10f. Zip Code: 20815

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Administrative Assistant

16b. Kind of Business/Industry: National Science Foundation

17. Father's Name (First, Middle, Last): Edward Jack Pearlove

18. Mother's Name (First, Middle, Maiden Surname): Katye Krupsaw

19a. Informant's Name/Relationship (Type, Print): Robert Levin - son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6385 Monitor Street Pittsburg, Pennsylvania 15217

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): King David Memorial Garden

Date: 3/16/2001

20c. Location - City or Town, State: Falls Church, Va.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Lung Cancer — 1 year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D33293

29d. Date signed (Month, Day, Year): March 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Frederick Smith, M.D. 5501 Western Avenue, N.W. Washington, D.C. 20015

**State Registrar**

31. Date filed (Month, Day, Year): MAR 16 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09403

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Elizabeth Lee-Boone
2. Date of Death Month / Day / Year: 3-6-2001
3. Time of Death: 12:30 PM
4a. Facility Name *(If not institution, give street and number)*: 757 St. Michaels Drive
4b. City, Town, or Location of Death: Mitchellville
4c. County of Death: P.G.

**Funeral Director**

5. Social Security Number: 057-46-6541
8. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 43 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 6-16-1957
9. Birthplace *(State or Foreign Country)*: Florida

Usual Residence of Decedent

10a. State: MD
10b. County: P.G.
10c. City, Town or Location: Mitchellville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 757 St. Michaels Drive
10f. Zip Code: 20721
10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - Americen Indien, Bleck, White, etc. *Specify:* Black

15. Decedent's Educetion *(Specify only highest grade completed)*: Elementery/Secondary (0-12): ; College (1-4or 5+): 2yrs.
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Secretary(Disabled)
16b. Kind of Business/Industry: Law Firm

17. Father's Name *(First, Middle, Last)*: Melvin Lee
18. Mother's Neme *(First, Middle, Maiden Sumame)*: Lessie Binns

19a. Informant's Name/Relationship *(Type, Print)*: Timothy Boone(Husband)
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 757 St. Michaels Dr. Mitchellville, MD 20721

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Mt. Olivet Cemetery
Dete: 3-12-01
20c. Location - City or Town, State: Washington, DC

21. Signeture of Funeral Service Licensee:
22. Name and Address of Facility: Austin Royster Funeral Home 3821 14th St. N.W. Wash.DC 20011

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complicetions that caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediete Cause (Finel diseese or condition resulting in death)
a. Brain Tumor — 1 month

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: Hyperthroidism

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No
24b. Ware autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding investigetion 6☐ Could not be determined
28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and mannar as stated. 2☐ **Medical Examiner**: On the besis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted.

29b. Signeture and title of certifier: Francyne Anderson
29c. License number: D19459
29d. Date signed *(Month, Day, Year)*: 3-10-01

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Francyne Anderson 6492 Landover Rd. Cheverly MD 20785

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 15 2001
32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09404

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): MARIE K. LEDER

2. Date of Death (Month, Day, Year): MARCH 13, 2001

3. Time of Death: 7:45 AM

4a. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSP'T.

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

**Funeral Director**

5. Social Security Number: 207-36-6632

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 94 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JUNE 23,1906

9. Birthplace (State or Foreign Country): CZECHOSLOVAKIA

Usual Residence of Decedent

10a. State: PA.

10b. County: ALLEGHENY

10c. City, Town or Location: GLENSHAW

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 133 MASON DR.

10f. Zip Code: 15116

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highast grada completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEWIFE

16b. Kind of Business/Industry: AT HOME

17. Father's Name (First, Middle, Last): BOHUMIL KORIZEK

18. Mother's Name (First, Middle, Maiden Sumame): UNKNOWN

19a. Informant's Name/Relationship (Type, Print): JAMES J. LEDER JR./SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11619 REGENCY DR., POTOMAC, MD. 20854

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Othar (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or othar piece): CHAMBERS CREMATORY

Dete: 3/14/01

20c. Location - City or Town, Stata: RIVERDALE, MD.

21. Signature of Funeral Service Licensee: W.W. Chambers II MO0091

22. Nama and Address of Facility: CHAMBERS FUNERAL HOMES,P.A., 5801 CLEVELAND AVE. RIVERDALE, MD.20737

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.

23b. Did tobacco use contributs to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Ware autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was casa referred to medical examinar? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Routa Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) end menner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, dete and place, and due to the cause(s) and menner stated.

29b. Signatura and title of certifier: Anushiravan Dadgar

29c. License number: H51280

29d. Date signed (Month, Dey, Year): MARCH 13, 2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): DR. ANUSHIRAVAN DADGAR, D.O. 13219 EXECUTIVE PARK TERR., GERMANTOWN,MD.20874

**State Registrar**

31. Data filed (Month, Day, Year): MAR 15 2001

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

6

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

2

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 09405

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: ALICE M. LANCASTER

2. Date of Death (Month, Day, Year): MARCH 7, 2001

3. Time of Death: 2:20 PM

4a. Facility Name *(If not institution, give street and number)*: Gladys Spellman Specialty & Nursing Center

4b. City, Town, or Location of Death: Cheverly

4c. County of Death: PRINCE GEORGES

**Funeral Director**

5. Social Security Number: 578-28-1447

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 25, 1915

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: None

10b. County: Nonl

10c. City, Town or Location: Washington, DC

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1623 C Street, SE

10f. Zip Code: 20003

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Give Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Rece - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementsry/Secondery (0-12): 12th | College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Domestic

16b. Kind of Business/Industry: Home

17. Father's Name *(First, Middle, Last)*: Matthew Copeland

18. Mother's Name *(First, Middle, Maiden Surneme)*: Anna Johnson

19a. Informant's Neme/Relationship *(Type, Print)*: William Powell (Son)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4900 8th Street, NE, Washington, DC 20017

20a. Mathod of Disposition: 1☒ Buriel 2☐ Cramation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, crematory or other piece)*: Ash Memorial Cem.

Data: 3/13/01

20c. Location - City or Town, State: Sandy Spring, MD

21. Signature of Funeral Service Licensee: George K. Snowden

22. Name and Address of Facility: SNOWDEN FUNERAL HOME, P.A. 246 N. Wash. St., Rockville,-MD

**Physician /Medical Examiner**

23e. Pert1. Enter tha diseasa, or complications that caused the daath. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failura. List only one cause on eech line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediata Cause (Final disease or condition resulting in death) a. | Sepsis | DAYS-WKS |
| Due to (or as a consequance of): b. | Cardio-yespiratory failure | WKS-month |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseasa or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c. | End Stage Rewal Failure | month-Year |
| Dua to (or as a consequence of): d. | Cerebro vascular accident | month-Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetes, Hypertension Anemia, Decubitus ulcer

23b. Did tobacco uss contribute to the cause of death? 1☐ Yss 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes an sutopsy performed? 1☐ Yes 2☒ No

24b. Were sutopsy findings availeble prior to complation of cause of death? 1☐ Yes 2☒ No

25. Was case referred to *medical* examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Othar *(Specify)*

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Sulcida 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of *my* knowledge, death occurred at tha time, date and place, end due to the cause(s) end *manner* es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in *my* opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D.

29c. License number: D0056184

29d. Date signed *(Month, Day, Year)*: 3-7-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JALAL SAIED, 3001 Hospital Dr. Cheverly, MD 20785

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 12 2001

32. Registrar's Signature: S. Sparks

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit order.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

4

DHMH 16 Rsv 6/95

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09406

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Jean C. Murphy
2. Date of Death (Month, Day, Year): March 12, 2001
3. Time of Death: 10:30 am
4a. Facility Name (If not institution, give street and number): 8809 Reading Road
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 220-58-6644
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov 14 1913
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10a. Street and Number: 8809 Reading Road
10f. Zip Code: 20901
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Patrick V. Curley
18. Mother's Name (First, Middle, Maiden Surname): Anna E. Schwarz

19a. Informant's Name/Relationship (Type, Print): Gerald Murphy / Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13170 Broadmore Rd., Silver Spring, MD 20904

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MD Veteran's Cemetery
Date: Mar 16 2001
20c. Location - City or Town, State: Cheltenham, Maryland

21. Signature of Funeral Service Licensee: ▶ Lawrence Parker
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Congestive Heart Failure | 1995 |
| Due to (or as a consequence of): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. | Atrial Fibrillation | 1995 |
| Due to (or as a consequence of): | | |
| c. | Hypertension | 1990 |
| Due to (or as a consequence of): | | |
| d. | Atherosclerotic Cardiovascular Disease | 1990 |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ HS Patrick III MD
29c. License number: D 17729
29d. Date signed (Month, Day, Year): March 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): George B. Patrick , III 9221 Colesville Road, Silver Spring, MD 20910

**State Registrar**

31. Date filed (Month, Day, Year): MAR 16 2001
32. Registrar's Signature: ▶ Brenda G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09407

**Physician /Medical Examiner**

1. Decedent's Neme (First, Middle, Last): Thomas William Mundy
2. Dete of Death: Month March Day 11 Year 2001
3. Time of Death: 710am
4a Facility Name (If not institution, give street and number): 1400 East West Highway #825
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 357-50-0091
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthdey): 47 Yrs.
If Under 1 Year: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec 6, 1953
9. Birthplace (State or Foreign Country): Illinois

Usuel Residence of Decedent

10a. Stete: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1400 East West Highway #825
10f. Zip Code: 20910
10g. Citizen of Whet Country?: United States

11. Maritel Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - Amerlcan Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12) / College (1-4or 5+): 5+
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Attorney
16b. Kind of Business/Industry: Legal System

17. Father's Neme (First, Middle, Last): Paul William Mundy
18. Mother's Neme (First, Middle, Maiden Surname): Mary Catherine Corcoran

19a. Informent's Name/Reletionship (Type, Print): Michael Franz /Brother-in-law
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 9415 Russell Rd, Silver Spring, MD 20910

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Remaval from State 4☐ Donation 5☐ Othar (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): St. Catherine's
Date: Mar 17 2001
20c. Location - City or Town, State: Moscow, PA

21. Signature of Funerel Service Licensee: Stephen D Lohmann M00382
22. Neme and Address of Feclility: Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, MD

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart teilure. List only one ceuse on eech line. — Approximate Interval Between Onset and Deeth

Immedlete Cause (Finel diseese or condition resulting in death): a. Metastatic Malignant Melanoma — 8 weeks

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or es a consequence of):

c.

Due to (or as a consaquance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Netural 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mennar steted.

29b. Signature and title of certifier: M Hawkins
29c. Licanse number: D 19757
29d. Date signed (Month, Day, Year): 3/13/01

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): Michael J. Hawkins, M.D., 110 Irving St. NW, Suite C-2151, Washington DC 20010

**State Registrar**

31. Date filed (Month, Day, Year): MAR 16 2001
32. Registrer's Signeture: Bruce B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09408

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Roberta S. Morman
2. Date of Death (Month, Day, Year): March 14, 2001
3. Time of Death: 6:00 AM
4a. Facility Name (If not institution, give street and number): Prince George's Hospital Center
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 579-26-9536
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 25, 1921
9. Birthplace (State or Foreign Country): South Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Fort Washington
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 9007 Pinehurst Road
10f. Zip Code: 20744
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 3 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Accounting Technician
16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): David Reeves
18. Mother's Name (First, Middle, Maiden Surname): Birdie Smalls

19a. Informant's Name/Reletionship (Type, Print): Olivee Neal / daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7920 Dartmoor Place, Port Tobacco, MD 20677

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Arlington National
Date: 3/23/01
20c. Location - City or Town, State: Arlington, VA

21. Signature of Funeral Service Licensee: Joanna E. Ellsberry
22. Name and Address of Facility: McGuire Funeral Service, Inc. 20012
7400 Georgia Avenue, N.W., Washington, D.C.

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | ACUTE STROKE | 3/6/01 |
| Due to (or as a consequence of): b. | CARDIOMYOPATHY WITH FAILURE | UNKNOWN |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c. | HUNTINGTON'S DISEASE | 2 YRS |
| Due to (or as a consequence of): d. | | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PNEUMOTHORAX

DEMENTIA - CHRONIC

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: S C Aryangat
29c. License number: D 15558
29d. Date signed (Month, Day, Year): 03/14/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): S C ARYANGAT, MD 3308 PERRY ST, MT. RAINIER, MD 20712

**State Registrar**

31. Date filed (Month, Day, Year): MAR 16 2001
32. Registrar's Signature: James B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

b

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ID

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 09409

**Physician /Medical Examiner**

1. Decedent's Nema *(First, Middle, Last)*: Carlos Montanaro
2. Data of Death Month Day Yaar: March 13, 2001
3. Tima of Death: 12:30 PM
4a. Facility Nema *(If not institution, give straat and number)*: Brooke Grove Rehabilitation & Nursing Center
4b. City, Town, or Location of Deeth: Sandy Spring
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 214-94-8244
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 87 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: August 8, 1913
9. Birthplaca *(State or Foreign Country)*: Paraguay

Usuel Rasidance of Decedent

10a. Steta: Maryland
10b. County: Montgomery
10c. City, Town or Location: Derwood
10d. Inside City Limits: 1☐ Yas 2☒ No
10e. Street end Number: 5609 Artesian Drive
10f. Zip Coda: 20855
10g. Citizan of What Country?: Paraguay
11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Give Yeer or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.): 1☒ Yas 2☐ No *Specify:* Paraguayan
14. Race - American Indian, Black, Whita, atc. *Specify:* White
15. Decedent's Education *(Specify only highast grada complatad)*: Elamentary/Secondary (0-12): – ; Collaga (1-4or 5+): 4
18a. Decedent's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT usa ratirad)*: General of the Army
16b. Kind of Businass/Industry: Paraguay
17. Fathar's Name *(First, Middla, Last)*: Sabino Montanaro
18. Mothar's Nama *(First, Middle, Maidan Surname)*: Dolores Ferriera
19a. Informant's Neme/Ralationship *(Type, Print)*: Adolfo E. Montanaro/ Son
19b. Mailing Addrass *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 5609 Artesian Drive, Derwood, Maryland 20855
20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from Stata 4☐ Donetion 5☐ Othar *(Specify)*
20b. Placa of Disposition *(Nama of cematary, cramatory or othar placa)*: Parklawn Memorial Park
Data: March 17, 2001
20c. Location - City or Town, Stata: Rockville, Maryland
21. Signature of Funeral Service Licensee: M008689
22. Nama and Address of Facility: Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

**To Be Completed by Funeral Director**

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0020**

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. ASPIRATION PNEUMONIA — 24 HOURS

Due to (or as a consequence of):
b. DYSPHAGIA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. ADVANCED PARKINSON'S DISEASE

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yas 2☐ No

25. Was case referred to medical examiner? 1☐ Yas 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residance 6☐ Othar *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 8☐ Could not be determined

28a. Data of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, State)*

29e. Cartifiar *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ted Howe.
29c. Licansa number: D33700
29d. Data signed *(Month, Day, Year)*: MARCH 13, 2001

30. Neme and address of person who completed cause of death (item 23a) (Type, Print): Ted E. Howe, M.D. 154 N. ARTIZAN STREET, WILLIAMSPORT, MD 21795

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

8

**State Registrar**

31. Data filed *(Month, Day, Year)*: MAR 16 2001
32. Registrar's Signatura: G. Sparks

DHMH 16 Rev 6/95

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09410

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Donald Matthew Meagher

2. Date of Death (Month, Day, Year): March 13, 2001

3. Time of Death: 5:00 am

4a. Facility Name *(If not institution, give street and number)*: 215 East University Blvd.

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 101-22-4374

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 71 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Feb 23, 1930

9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 215 East University Blvd.

10f. Zip Code: 20901

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): College (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Computer Systems Analyst

16b. Kind of Business/Industry: Federal Government

17. Father's Name *(First, Middle, Last)*: Thomas Francis Meagher

18. Mother's Name *(First, Middle, Maiden Surname)*: Alice McHugh

19a. Informant's Name/Relationship *(Type, Print)*: Iris Meagher / Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 215 East University Blvd., Silver Spring, MD 20901

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, cremetory or other place)*: Metropolitan Crematory

Date: Mar 14 2001

20c. Location - City or Town, State: Alexandria, VA

21. Signature of Funeral Service Licensee: Robert D. Sykes

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

**Physician /Medical Examiner**

23a. Part I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Hepatic failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hepatic Cirrhosis

Due to (or as a consequence of):

c. Hemochromatosis

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Nicholas Manjuk MD

29c. License number: D-14888

29d. Date signed *(Month, Day, Year)*: 3/14/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Nicholas Manjuk, MD 2100 Pennsylvania Ave, NW, Washington, DC

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 16 2001

32. Registrar's Signature: Barbara G. Marks

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

10

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09411

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Thelma H. Ann McElveen
2. Data of Death Month Day Year: March 12, 2001
3. Time of Death: 220pm
4a. Facility Name (If not institution, give street and number): 2208 Colston Dr. #102
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 579-34-5824
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 68 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Nov 18, 1932
9. Birthplace (State or Foreign Country): SC

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☐ No
10a. Street and Number: 2208 Colston Dr. #102
10f. Zip Code: 20901
10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Speech Pathologist
16b. Kind of Business/Industry: Educational System

17. Father's Name (First, Middle, Last): Wallie McElveen
18. Mother's Name (First, Middle, Maiden Surname): Carrie Rainey

19a. Informant's Name/Relationship (Type, Print): Etoile Hawkins /Friend
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1706 Terrapin Hills Dr., Mitchellville, MD 20721

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory
Date: March 19, 2001
20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: Stephen D. Lohmann
22. Name and Address of Facility: Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, MD

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Lung Cancer — Unknown
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: J. Garrett Reilly MD PhD
29c. License number: D39190
29d. Date signed (Month, Day, Year): March 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Garrett Reilly MD PhD ; 3418 Olandwood Ct. #111; Olney Md 20832

**State Registrar**

31. Date filed (Month, Day, Year): MAR 16 2001
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09412

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Marie B. McCully
2. Date of Death (Month, Day, Year): March 8, 2001
3. Time of Death: 3:30 am
4a. Facility Name (If not institution, give street and number): Brooke Grove Nursing Home
4b. City, Town, or Location of Death: Sandy Spring
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 578-32-6595
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb 17, 1920
9. Birthplace (State or Foreign Country): Nebraska

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Sandy Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 18131 Slade School Road
10f. Zip Code: 20869
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Stanley E. Badura
18. Mother's Name (First, Middle, Maiden Surname): Bertha Jamrog

19a. Informant's Name/Relationship (Type, Print): Daniel R. McCully/ Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4615 N. Park Avenue, #1111, Chevy Chase, MD 20815

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Gate of Heaven Cemetery
Date: Mar 12 2001
20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: John E. Faber
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode ot dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death): a. Pneumonia — 6 weeks

Due to (or es a consequence ot):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. CVA
Due to (or es a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Type I Diabetes

Alzheimer's Disease

Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Christopher J. Mays
29c. License number: D 39793
29d. Date signed (Month, Day, Year): March 8, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Christopher J. Mays, MD 12102 Georgia Ave., Wheaton, MD 20902

**State Registrar**

31. Date filed (Month, Day, Year): MAR 12 2001
32. Registrar's Signature: Lenore B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit copy.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09413

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Robertine McCauley, C.S.C. AKA Maryanne McCauley
2. Date of Death (Month, Day, Year): March 6, 2001
3. Time of Death: 1:15 am

4a. Facility Name *(If not institution, give street and number)*: Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 465-86-6754
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 5, 1929
9. Birthplace *(State or Foreign Country)*: New Jersey

Usual Residence of Decedent

10a. State: None
10b. County: None
10c. City, Town or Location: Washington, DC
10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 1301 14th Street, NW #300
10f. Zip Code: 20005
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Educator/ Program Director
16b. Kind of Business/Industry: Elementary Education/ Homeless Shelter

17. Father's Name *(First, Middle, Last)*: Robert S. McCauley
18. Mother's Name *(First, Middle, Maiden Surname)*: Helen Marie Hart

19a. Informant's Name/Relationship *(Type, Print)*: Katherine Kase, C.S.C./ Friend
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1301 14th Street, NW #300, Washington, DC 20005

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery | Date: Mar 13 2001
20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: Eric L Sparks
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Intracerebral Hemmorage with Intraventricular extension

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Neurologist
29c. License number: D 21691
29d. Date signed *(Month, Day, Year)*: 3·12·2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Rosita Dee, MD 8830 Cameron Street Suite 207, Silver Spring, MD 20901

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 15 2001
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 09414

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Clemmer B. Marcus
2. Date of Death (Month, Day, Year): March 11, 2001
3. Time of Death: 6:45A.
4a. Facility Name *(If not institution, give street and number)*: HCR-Manor Care
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 219-01-8843
8. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 83 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jan.5,1918
9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Beltsville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 4003 Howard Road
10f. Zip Code: 20705
10g. Citizen of What Country?: United States
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1943-1946
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12; College (1-4or 5+): 4
18a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Grain Marketing Specialist
16b. Kind of Business/Industry: United States Dept. of Agriculture
17. Father's Name *(First, Middle, Last)*: William Mayo Marcus
18. Mother's Name *(First, Middle, Maiden Surname)*: Lutie Virginia Marcus
19a. Informant's Name/Relationship *(Type, Print)*: Edith H. Marcus - Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: same as #10a - 10g
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Fort Lincoln Cemetery
Date: 3/14/2001
20c. Location - City or Town, State: Brentwood, Maryland
21. Signature of Funeral Service Licensee: Donald V Borgwardt
22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. C.H.F.

Due to (or as a consequence of):
Hypertension

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
Alzheimers Disease

c.

Due to (or as a consequence of):
B12 Deficiency Anaemia

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Kirti Vohra M.D
29c. License number: D20274
29d. Date signed *(Month, Day, Year)*: March 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kirti Vohra, M.D. 7710 Bradley Boulevard Bethesda, Maryland 20817

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 14 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

GF

13

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09415

MANGUS

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Anna Mangus

2. Date of Death (Month, Day, Year): March 9 2001

3. Time of Death: 3:30 PM

4a. Facility Name *(If not institution, give street and number)*: SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

**Funeral Director**

5. Social Security Number: 174-16-0154

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 24, 1920

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Germantown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 20908 Severndale Terrace

10f. Zip Code: 20876

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Charles Zadik

18. Mother's Name *(First, Middle, Maiden Surname)*: Sophia Zoldak

19a. Informant's Name/Relationship *(Type, Print)*: Benjamin C. Mangus/Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 20908 Severndale Terrace, Germantown, MD 20876

20a. Mathod of Disposition: 1☐ Burial 2☒ Cremation 3☐ Ramoval from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other piece)*: Montgomery Crematorium, Inc. Date: March 16, 2001

20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funaral Service Licensee: ▶ Will E Brown Jr M00672

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

6

**Physician /Medical Examiner**

23a. Part1. Enter tha disaasa, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death)
a. Brady arrhythmia — Minute

Due to (or as a consequence of):
b. Myocardial infarction — Day

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Pulmonary fibrosis, chronic obstructive pulmonary disease

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

12

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Alan J Chanales

29c. License number: 29450

29d. Date signed *(Month, Day, Year)*: March 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ALAN CHANALES 15225 SHADY GROVE RD ROCKVILLE MD 20850

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 12 2001

32. Registrar's Signature: ▶ B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend #8, 3/19/2001, BMW, Montg. Co

# Certificate of Death

2001 09416
Reg. No.

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| RUTH E. MACKALL | MARCH 8, 2001 | 12:55 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Laurel Regional Hospital | Laurel | PRINCE GEORGES |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-14-7387 | 1☐M 2☒F | 86 Yrs. | | | May 29 ~~Sept. 14~~, 1914 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Prince Georges | Cottage City | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 4142 Bunker Hill Road | 20722 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 7th | | Domestic | Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| John Mackall | Letha Offer |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Phyllis Matthews (Daughter) | 611 10th Street, Laurel, MD 20707 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Metro Funeral Srv. | 3/14/01 | Alexandria, VA |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| George E. Snowden | SNOWDEN FUNERAL HOME, P.A. 246 N. Wash. St., Rockville, MD 20350 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Left Cerebrovascular Accident | 3 days |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Acute Myocardial Infarction

Dehydration

Dementia

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☐No 3☐Probably 4☒Unknown | 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ M.D | D24721 | Mar. 8, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Syed Sadiq, M.D. 14333 Laurel-Bowie Rd., Laurel, MD 20708

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 12 2001 | B. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

3

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09417

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Paul Vincent Noonan
2. Date of Death (Month, Day, Year): Mar 11, 2001
3. Time of Death: 4:19 pm
4a. Facility Name *(If not institution, give street and number)*: Homewood @ Crumland Farms
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

**Funeral Director**

5. Social Security Number: 030-24-1692
6. Sex: 1☒M 2☐F
7. Age *(In yrs. last birthday)*: 68 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jun 23, 1932
9. Birthplace *(State or Foreign Country)*: Massachusetts

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 7407 Willow Road
10f. Zip Code: 21702
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: 1952-1956
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12); College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Civil Engineer
16b. Kind of Business/Industry: Bechtol Power

17. Father's Name *(First, Middle, Last)*: Jeremiah Edward Noonan
18. Mother's Name *(First, Middle, Maiden Surname)*: Gertrude Regina Kelly

19a. Informant's Name/Relationship *(Type, Print)*: Patricia Brooks/Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 331 East Third Street, Frederick, Maryland 21701

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Smithsburg Crematory
Date: Mar 15, 2001
20c. Location - City or Town, State: Smithsburg, MD

21. Signature of Funeral Service Licensee: [signature] MOO706
22. Name and Address of Facility: Keeney & Basford P.A. Funeral Home, 106 East Church St, Frederick, Maryland 21701

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Alzheimer's dementia — 10 years
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: History of 2 strokes, pneumonia, gastroesophageal reflux

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☒Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D35183
29d. Date signed *(Month, Day, Year)*: 3/12/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Ali J. Afrookteh 300 W 9th St, Frederick, MD

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 14 2001
32. Registrar's Signature: [signature]

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09418

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Dorothy K. Nutter
2. Date of Death (Month, Day, Year): March 12, 2001
3. Time of Death: 12:02 AM
4a. Facility Name (If not institution, give street and number): Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 160-05-1260
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan 18, 1912
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 801 McCeney Ave.
10f. Zip Code: 20901
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): John F. Kolb
18. Mother's Name (First, Middle, Maiden Surname): Clara Holzhauer

19a. Informant's Name/Relationship (Type, Print): John B. Nutter / Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 801 McCeney Ave. Silver Spring, Maryland 20901

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Fort Lincoln Crematory
Date: 3-13-01
20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Hines-Rinaldi Funeral Home Inc. 11800 New Hampshire Ave. Silver Spring, MD. 20904

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Sepsis | days |
| Due to (or as a consequence of): | | |
| b. | Pneumonia | days |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c. | | |
| Due to (or as a consequence of): d. | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Breast Cancer

atrial fibrillation

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D 53411
29d. Date signed (Month, Day, Year): March 12th 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JC Shesadri 3060 mitchellville Rd # 103 Bowie MD 20716

**State Registrar**

31. Date filed (Month, Day, Year): MAR 15 2001
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

JB

AMEND ITEM#17 PER INFMNT. G803 1-25-02 *Certificate of Death*

Reg. No. 2001 09419

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner** — **Funeral Director** — **To Be Completed by Funeral Director**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|
| Despina Nicholas | | March 7, 2001 | 6:00PM |
| **4a. Facility Name** (If not institution, give street and number) | **4b. City, Town, or Location of Death** | **4c. County of Death** | |
| Manor Care - Chevy Chase | Chevy Chase | Montgomery | |

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 444-38-8529 | 1☐ M 2☒ F | 66 Yrs. | | | | | July 26,1934 | Greece |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Montgomery | Silver Spring | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1730 Dublin Drive | 20902 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No *Specify:* | *Specify:* White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Neme (First, Middle, Meiden Surname) |
|---|---|
| PANAGIOTI ~~Spiro~~ Zembekou | Angelike Mavrodontis |

| 19a. Informant's Neme/Relationship (Type, Print) | 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) |
|---|---|
| Constantine J. Nicholas (husband) | 1730 Dublin Drive Silver Spring,Maryland 20902 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Buriel 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Other (Specify) | Gate of Heaven Cemetery | 3/10/01 | Silver Spring,Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ John E. Parker | Francis J. Collins Funeral Home, Inc. 500 University Blvd.,W.,Silver Spring,MD 20901 |

**Physician /Medical Examiner** — **Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Multiple Myeloma | Years |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. | |
| | Due to (or as e consequenca of): | |
| | c. | |
| | Due to (or as a consequenca of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☒ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Ruth Kevess-Cohen MD | D 33159 | March 9, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ruth Kevess-Cohen, M.D. 8700 Georgia Avenue #400 Silver Spring, Maryland 20910

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 12 2001 | ▶ Lawrence G. Sparks |

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

10

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09420

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Margaret Howells Owens
2. Date of Death (Month, Day, Year): March 9, 2001
3. Time of Death: 8:29PM
4a. Facility Name (If not institution, give street and number): 5807 Aberdeen Road
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 457-78-2426
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 43 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 30, 1957
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5807 Aberdeen Road
10f. Zip Code: 20817
10g. Citizen of What Country?: United States

11. Meritel Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondery (0-12); College (1-4or 5+): 3
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Henry Coggeshall Howells, Jr.
18. Mother's Neme (First, Middle, Meiden Surneme): Margaret Keller

19a. Informant's Neme/Reletionship (Type, Print): Thomas G. Owens/Husband
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 5807 Aberdeen Road, Bethesda, Maryland 20817

20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Parklawn Memorial Park
Dete: Mar. 14, 2001
20c. Location - City or Town, Stete: Bethesda, Maryland

21. Signature of Funerel Service Licensee: [signature] M00198
22. Neme end Address of Fecility: Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

**Physician /Medical Examiner**

23a. Pert1. Enter the disease, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Deeth

Immediate Cause (Finel disease or condition resulting in death): a. Metastatic Breast Cancer — 2 years

Dua to (or as a consequence ot):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest

b. Due to (or as a consequence of):

c. Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, snd due to tha cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date end place, and dua to the cause(s) and manner steted.

29b. Signature and title of certifier: [signature]
29c. License number: D26633
29d. Dete signed (Month, Day, Year): March 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Frederick P. Smith, M.D. 5401 Western Avenue, N.W. Washington, D.C. 20016

**State Registrar**

31. Date filed (Month, Day, Year): MAR 19 2001
32. Registrer's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

---

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Amended item#5 FCHD,KS 03/21/01 **Certificate of Death** Reg. No. 2001 09421

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Physician /Medical Examiner**

**Funeral Director**

1. Decedent's Name (First, Middle, Last): Gladys Mary Pollock
2. Date of Death: Month March Day 11, Year 2001
3. Time of Death: 5:03am
4a. Facility Name (If not institution, give street and number): Homewood @ Crumland Farms
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick
5. Social Security Number: ~~001-14-2606~~ 001-14-4606
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 4, 1919
9. Birthplace (State or Foreign Country): Massachusetts

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7407 Willow Road
10f. Zip Code: 21702
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yas 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highast grada complated): Elementary/Secondary (0-12): | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Office Administrator
16b. Kind of Business/Industry: Federal Government
17. Father's Nama (First, Middle, Last): Michael Joseph GIBBONS
18. Mother's Name (First, Middle, Maiden Surname): Margaret Josephine O'Grady
19a. Informant's Name/Relationship (Type, Print): Margaret Reed/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8026 Cattail Court, Frederick, Maryland 21701
20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Columbia Gardens Mar 13, Date: 2001
20c. Location - City or Town, State: Arlington, Virginia
21. Signature of Funeral Service Licensee: Kathryn Roberson M00706
22. Name and Address of Facility: Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused tha daath. Do not enter tha moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causa on each lina. — Approximate Interval Batween Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia — 3 weeks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.: Microvascular Ischemic Cerebralvascular Disease

23b. Did tobacco use contributa to the cause of death? 1☐ Yas 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yas 2☒ No

26. Place of Death (Check only ona): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Casper E. Cline MD
29c. License number: D16428
29d. Data signed (Month, Day, Year): March 12, 2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): Casper E. Cline, III, M.D., 300 West Ninth Street, Frederick, Maryland 21701

**State Registrar**

31. Data filed (Month, Day, Year): MAR 13 2001
32. Registrar's Signature: Bonnie B Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09422

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Betty Mae Perkins
2. Date of Death (Month, Day, Year): March 11, 2001
3. Time of Death: 9:50 P.M.

4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

**Funeral Director**

5. Social Security Number: 235-32-0312
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): October 5, 1927
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Adamstown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5400 Village Court
10f. Zip Code: 21710
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Assembler
16b. Kind of Business/Industry: Optical Company

17. Father's Name (First, Middle, Last): Neil Kirby
18. Mother's Name (First, Middle, Maiden Surname): Mae Fellers

19a. Informant's Name/Relationship (Type, Print): Susan Denise Marsel/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5400 Village Court, Adamstown, Maryland 21710

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Olivet Cemetery
Date: March 14, 2001
20c. Location - City or Town, State: Frederick, Md.

21. Signature of Funeral Service Licensee: Richard C. C. Basford M00021
22. Name and Address of Facility: Keeney and Basford Funeral Home 106 East Church Street, Frederick, Md. 21701

**Physician /Medical Examiner**

23a. Part1. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. CARDIORESPIRATORY ARREST
Due to (or as a consequence of): CVA
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. CVA
Due to (or as a consequence of): ATRIAL FIBRILLATION
c. ATRIAL FIBRILLATION
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D39846
29d. Date signed (Month, Day, Year): March 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sean E. Hunt, M.D., 310 West Ninth Street, Frederick, Maryland 21701

**State Registrar**

31. Date filed (Month, Day, Year): MAR 14 2001
32. Registrar's Signature: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09423

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Thaddeus Joseph Polit, Sr.
2. Date of Death (Month, Day, Year): March 12, 2001
3. Time of Death: 4:10AM
4a. Facility Name (If not institution, give street and number): Montgomery General Hospital
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 349-05-3785
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 9,1915
9. Birthplace (State or Foreign Country): Illinois

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Brookeville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 18661 Queen Elizabeth Drive
10f. Zip Code: 20833
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1945-46
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Accountant
16b. Kind of Business/Industry: Food Services

17. Father's Name (First, Middle, Last): John Polit
18. Mother's Name (First, Middle, Maiden Surname): Caroline (unobtainable)

19a. Informant's Name/Relationship (Type, Print): Thaddeus J. Polit, Jr./Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 18661 Queen Elizabeth Drive Brookeville, MD 20833

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery
Date: 3/15/01
20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: Anthony L. DiMeo
22. Name and Address of Facility: Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave. Silver Spring, MD 20904

**Physician /Medical Examiner**

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | DILATED ISCHEMIC CARDIOMYOPATHY | years |
| Due to (or as a consequence of): b. | CORONARY ARTERY DISEASE | years. |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c. | | |
| Due to (or as a consequence of): d. | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D38457
29d. Date signed (Month, Day, Year): MARCH 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): N. GOMAL MD 3801 INTERNATIONAL DR #211, S. SPRING, MD 20906

**State Registrar**

31. Date filed (Month, Day, Year): MAR 15 2001
32. Registrar's Signature: [signature] B. Sparks

DHMH 16 Rev 6/95

---

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

20

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Amend #24a,26,3/14/2001,BMW,Montg.Co

# Certificate of Death

Reg. No. 2001 09424

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): MARY ELIZABETH POINTER
2. Date of Death: Month MARCH Day 12 Year 2001
3. Time of Death: 9:00AM
4a. Facility Name (If not institution, give street and number): SUBURBAN HOSP. 8600 O'Donnell
4b. City, Town, or Location of Death: BETHESDA
4c. County of Death: MONTGOMERY

**Funeral Director**

5. Social Security Number: 225-98-3854
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 84 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JUL 29, 1916
9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedent

10a. State: VA
10b. County:
10c. City, Town or Location: HAMPTON
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 929 WILSON LANE
10f. Zip Code: 23663
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MAINTENANCE
16b. Kind of Business/Industry: U.S. GOVT

17. Father's Name (First, Middle, Last): WALTER RIDDICK
18. Mother's Name (First, Middle, Maiden Surname): SADIE DIXON

19a. Informant's Name/Relationship (Type, Print): THELMA PEOPLES-DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5821 EDSON LANE #204 ROCKVILLE MD 20852

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): COLOSSIAN BAPTIST CH
Date: 3-16-2001
20c. Location - City or Town, State: NEWPORT NEWS, VA

21. Signature of Funeral Service Licensee: CC0348
22. Name and Address of Facility: Latney's Funeral Home 3831 Georgia Ave NW Wash. DC 20011

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. ACUTE CARDIAC ARREST

Due to (or as a consequence of):
b. SEPSIS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):
d. MYOCARDIAL INFARCTION

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Attan Kasid MD PhD
29c. License number: D 55054
29d. Date signed (Month, Day, Year): MARCH 12 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ATTAN KASID 17519 REDLAND AV ROCKVILLE

**State Registrar**

31. Date filed (Month, Day, Year): MAR 14 2001
32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

**To Be Completed by Funeral Director**

A permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Pointer, Mary 03-13-2001 9:00 AM

12

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 09425

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Mark H. Pillor

2. Date of Death Month Day Year: March 10, 2001

3. Time of Death: 11:52 PM

4a. Facility Name *(If not institution, give street and number)*: Casey House

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 558-40-3494

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jul 11, 1931

9. Birthplace *(State or Foreign Country)*: Wisconsin

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 1536 Winding Way Ln

10f. Zip Code: 20902

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1952-1954

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) | College (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Family Physician

16b. Kind of Business/Industry: Medicine

17. Father's Name *(First, Middle, Last)*: Frasier H. Pillor

18. Mother's Name *(First, Middle, Maiden Surname)*: Kristine Odegaard

19a. Informant's Name/Relationship *(Type, Print)*: Peggy Pillor/Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1536 Winding Way Ln, Silver Spring, MD 20902

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Norbeck Memorial Park

Date: Mar 14

20c. Location - City or Town, State: Olney, MD

21. Signature of Funeral Service Licensee: ▶ Alan J Donnell

22. Name and Address of Facility: Hines-Rinaldi Funeral Home 11800 New Hampshire Ave, Silver Spring, MD 20904

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Parkinson's Disease — Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ S. Newman MD

29c. License number: D15046

29d. Date signed *(Month, Day, Year)*: March 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen J. Newman 19261 Montgomery Village Ave, Montgomery Village, MD 20886

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 15 2001

32. Registrar's Signature: ▶ Geneva G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09426

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Marjorie C. Pearce
2. Date of Death (Month, Day, Year): March 10, 2001
3. Time of Death: 4:30 am
4a. Facility Name (If not institution, give street and number): Montgomery Hospice- Casey House
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 261-16-9666
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Mar 19, 1918
9. Birthplace (State or Foreign Country): Florida

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Boyds
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 22005 Ridge View Road
10f. Zip Code: 20841
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementery/Secondary (0-12): 12
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Marion O. Causey
18. Mother's Name (First, Middle, Maiden Surname): Kate A. Deen

19a. Informant's Name/Relationship (Type, Print): Marion Roland Fritter/ Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9105 Louis Avenue, Silver Spring, MD 20910

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): George Washington Cemetery
Date: Mar 13 2001
20c. Location - City or Town, State: Adelphi, MD

21. Signature of Funeral Service Licensee: James S Dooley
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Senile Chorea — months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Due to (or as e consequence of):
c. Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Pneumonia

Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and manner stated.

29b. Signeture end title of certifier: Steven Newman MD
29c. License number: D 15046
29d. Dete signed (Month, Day, Year): March 10, 2001

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print): Steven Newman, MD 19261 Montgomery Village Ave, Montgomery Village, MD 20886

**State Registrar**

31. Date filed (Month, Day, Year): MAR 12 2001
32. Registrar's Signature: Lauren B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09427

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): George Patricio
2. Date of Death Month Day Year: 3-4-2001
3. Time of Death: 9:35PM
4a. Facility Name (If not institution, give street and number): 3378 Chiswick Crt.(Leisure World)
4b. City, Town, or Location of Death: Siver Spring
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 548-10-0922
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 93 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 2-16-1908
9. Birthplace (State or Foreign Country): P.A.

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3378 Chiswick Crt.(Leisure World)
10f. Zip Code: 20906
10g. Citizen of What Country?: US
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: Army 1943-1947
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): ; College (1-4or 5+): 4 yrs.
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Contractor
16b. Kind of Business/Industry: Terrazzo Contractors
17. Father's Name (First, Middle, Last): John Patricio
18. Mother's Name (First, Middle, Maiden Surname): Anna Epelliarin
19a. Informant's Name/Relationship (Type, Print): Rosa Patricio(Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3378 Chiswick Crt.(Leisure World),Silver SpringMD 20906
20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from Stete 4 [X] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Georgetown Med. School
Date: 3-4-2001
20c. Location - City or Town, Stete: Washington,DC
21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: Austin Royster Funeral Home 3821 14th St. N.W. Wash.DC 20011

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Congestive Heart Failure | 5 years |
| Due to (or as a consequence of): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. | Severe Aortic Stenosis | 6 years |
| Due to (or as a consequence of): | | |
| c. | | |
| Due to (or as a consequence of): | | |
| d. | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner steted.

29b. Signature end title of certifier: John A Rossi MD
29c. License number: D24543
29d. Date signed (Month, Day, Year): March 13, 2001

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): James A Rossi, 3305 N. Leisure World Blvd., Silver Spring, MD 20906

**State Registrar**

31. Dete filed (Month, Day, Year): MAR 14 2001
32. Registrar's Signature: Bernice G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 09428

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Thomas Stephen Quarles
2. Date of Death (Month, Day, Year): March 7, 2001
3. Time of Death: 620 a M
4a. Facility Name (If not institution, give street and number): Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 455-64-9086
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 59 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct 1, 1941
9. Birthplace (State or Foreign Country): TX

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 507 Margaret Dr.
10f. Zip Code: 20910
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Staff Associate
16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): Stephen Francis Quarles
18. Mother's Name (First, Middle, Maiden Surname): Blanche Brown

19a. Informant's Name/Relationship (Type, Print): Lynn Quarles /Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 507 Margaret Dr., Silver Spring, MD 20910

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory
Date: Mar 10 2001
20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: ▶ Beverly R. Herbutte
22. Name and Address of Facility: Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, MD

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. RESPIRATORY FAILURE — Approximate Interval Between Onset and Death: 1 DAY

Due to (or as a consequence of):
b. HYPOVENTILATION — 1 WK

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. ENCEPHALOPATHY — 2 WKS

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
STATUS EPILEPTICUS, DIABETES MELLITUS, HYPERTENSION, SYNCOPE

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
28. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Steven Tikey — MD
29c. License number: D36252
29d. Date signed (Month, Day, Year): MARCH 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): STEVEN T. KARIYA, MD, 11501 GEORGIA AVE, STE. 515, WHEATON MD 20902

**State Registrar**

31. Date filed (Month, Day, Year): MAR 13 2001
32. Registrar's Signature: ▶ B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09429

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Clayton I. Remsburg

2. Date of Death: Month March Day 14 Year 2001

3. Time of Death: 4:08 a.m.

4a. Facility Name (If not institution, give street and number): 204 Crestview Court

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

**Funeral Director**

5. Social Security Number: 219-05-2699

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months Days

If Under 24 Hrs.: Hours Min.

8. Date of Birth (Month, Day, Year): 5/21/1919

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 204 Crestview Court

10f. Zip Code: 21702

10g. Citizen of What Country? United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Produce Manager

16b. Kind of Business/Industry: Grocery Store

17. Father's Name (First, Middle, Last): John W. Remsburg, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Lutie B. Spessard

19a. Informant's Name/Relationship (Type, Print): Beverly Pellicot/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4908 Shadywood Drive Jefferson, MD 21755

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Olivet Cemetery

Date: 3/17/2001

20c. Location - City or Town, State: Frederick, MD

21. Signature of Funeral Service Licensee: Raymond Peterson

22. Name and Address of Facility: Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, MD 21702

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Adenocarcinoma of Lung — 2 mos

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robert L. Kaufman

29c. License number: D-13971

29d. Date signed (Month, Day, Year): 3/14/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert L. Kaufman, MD, 300 West 9th St./ Frederick, MD 21702

**State Registrar**

31. Date filed (Month, Day, Year): MAR 15 2001

32. Registrar's Signature: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 09430

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Data of Death Month Day Yaar | 3. Tima of Daath |
|---|---|---|
| Helen Julia Rothman | March 2, 2001 | 9:52 P. M |

| 4a. Facility Nema (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Holy Cross Hospital | Silver Spring | Montgomery |

**Funeral Director**

| 5. Social Security Number | 6. Sax | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Data of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 109-28-9443 | 1☐M 2☒F | 81 Yrs. | | | Aug. 5, 1919 | Czechoslovakia |

Usual Residence of Decedent

| 10a. Stata | 10b. County | 10c. City, Town or Location | 10d. Insida City Limits |
|---|---|---|---|
| Md | Montgomery | Silver Spring | 1☒Yas 2☐No |

| 10e. Street and Number | 10f. Zip Coda | 10g. Citizen of What Country? |
|---|---|---|
| 1131 University Blvd., W. Apt. 1503 | 20902 | U. S. A. |

| 11. Marital Status | 12. Was Decedent Evar in U.S. Armed Forces? | 13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) | 14. Race - Amarican Indian, Black, Whita, etc. |
|---|---|---|---|
| 1☐Nevar Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yas 2☒No If Yes, Give Yaar or Dates: | 1☐Yas 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | Collega (1-4or 5+) | | |
| 12 Years | | Homemaker | Own Home |

| 17. Fathar's Nama (First, Middle, Last) | 18. Mother's Nema (First, Middle, Maiden Surname) |
|---|---|
| Israel Cikk | Malka Farkas |

| 19a. Informant's Name/Ralationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Ruby Rakes - Daughter | 1131 University Blvd., West, Apt. 1503 Silver Spring, Maryland 20902 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, cremetory or other piece) | Data | 20c. Location - City or Town, Stata |
|---|---|---|---|
| 1☒Burial 2☐Cramation 3☐Ramoval from State 4☐Donation 5☐Othar (Specify) | Mount Lebanon Cem. | 3/3/2001 | Adelphi, Maryland |

21. Signatura of Funaral Sarvice Licensee: ▶ Donald S. Stottlemyer

22. Name and Address of Facility: DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

**Physician /Medical Examiner**

23a. Part I. Enter the disaasa, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory errast, shock, or haart failura. List only one causa on each line.

Sequentially list conditions, if any, leading to immediata cause. Entar Undarlying Cause (Disaasa or injury that initiatad avants rasulting in death) Last

| | | Approximata Intarvat Batwaan Onsat and Death |
|---|---|---|
| Immediate Cause (Final disaasa or condition rasulting in death) a. | Respiratory Failure | 1 Week |
| Dua to (or as a consequence of): b. | Hypoventilation Syndrome | 5 Years |
| Dua to (or as a consequence of): c. | Chronic Obstructive Pulmonary Disease | 10 Years |
| Dua to (or as a consequence of): d. | | |

| IF FEMALE: 23b. Was decedant pregnant in tha past 12 months? | 23c. If yas, outcoma of pregnancy | 23d. Data of dalivary Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal daath 3☐Ectopic pregnancy 4☐Pregnent at time of death 5☐Othar (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in tha undarlying causa givan in Part I.

Obesity, Obstructive Sleep Apnea, Incontinence of Stool and Urine, Superficial Cellulitis Osteoarthritis

| 23e. Did tobacco usa contributa to tha causa of death? | 24a. Was an autopsy performed? | 24b. Ware autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yas 2☐No 3☐Probably 4☐Unknown | 1☐Yas 2☒No | 1☐Yas 2☐No |

| 25. Was case referrad to medical examiner? | 26. Place of Daath (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Rasidance 6☐Other (Specify) |

| 27. Manner of Daath | 28a. Data of Injury (Month, Day Yaer) | 28b. Tima of Injury | 28c. Injury at Work? | 28d. Dascribe how injury occurred |
|---|---|---|---|---|
| 1☒Naturat 2☐Accidant 3☐Suicida 4☐Homicida 5☐Pending investigation 6☐Could not be datarmined | | M | 1☐Yas 2☐No | |
| | 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) |

29a. Certifier (Check only one): 1☒Certifying Physician: To tha bast of my knowladga, death occurrad at tha tima, data and placa, and due to the cause(s) and mannar as stated. 2☐Medical Examiner: On tha basis of axaminetion and/or investigation, in my opinion, daath occurrad at the time, data and placa, and due to the cause(s) and mannar stated.

| 29b. Signatura and titla of certifiar | 29c. License numbar | 29d. Data signed (Month, Day, Year) |
|---|---|---|
| ▶ Steven T. Kariya MD | D36252 | March 3, 2001 |

30. Nama and addrass of parson who completed cause of daath (Item 23a) (Type, Print): Steven T. Kariya, M.D. 11501 Georgia Avenue, # 515, Wheaton, Maryland 20902

**State Registrar**

| 31. Data filed (Month, Day, Year) | 32. Registrar's Signatura |
|---|---|
| MAR 13 2001 | ▶ B. Sparks |

DHMH 17 Rav 1/2001

ORIGINAL

---

**Baltimore, Maryland 21215-0036**

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09431

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Ann Marie Romano
2. Date of Death (Month, Day, Year): March 13, 2001
3. Time of Death: 4:40 pm
4a. Facility Name (If not institution, give street and number): 14610 Old Lyme Drive
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 218-19-1326
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 27 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec 13, 1973
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 14610 Old Lyme Drive
10f. Zip Code: 20905
10g. Citizen of What Country: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Lawrence J. Gaffigan
18. Mother's Name (First, Middle, Maiden Surname): Ellen M. Carroll

19a. Informant's Name/Relationship (Type, Print): Christopher Romano/ Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14610 Old Lyme Drive, Silver Spring, MD 20905

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Gate of Heaven Cemetery
Date: Mar 17 2001
20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: James E Dodge
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. acute myelogenous leukemia — 6mo

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Graft versus host disease

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D35254
29d. Date signed (Month, Day, Year): 3/14/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CARROLL MILLER , MD 401 N. Broadway Street, Baltimore, MD

**State Registrar**

31. Date filed (Month, Day, Year): MAR 16 2001
32. Registrar's Signature: [signature] B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 09432

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Regina Norma Rogers
2. Date of Death Month / Day / Year: March 9, 2001
3. Time of Death: 1:35P.
4a. Facility Name *(If not institution, give street and number)*: 5113 Iroquois Street
4b. City, Town, or Location of Death: College Park
4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 577-26-0930
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 78 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Nov.11,1922
9. Birthplace *(State or Foreign Country)*: Washington,D.C.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: College Park
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 5113 Iroquois Street
10f. Zip Code: 20740
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife
16b. Kind of Business/Industry: own home

17. Father's Name *(First, Middle, Last)*: Archibald B. Fletcher
18. Mother's Name *(First, Middle, Maiden Surname)*: Marie Shea

19a. Informant's Name/Relationship *(Type, Print)*: Ronald E. Rogers - son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: same as #10a - 10g

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Olivet Cemetery
Date: 3/13/2001
20c. Location - City or Town, State: Washington, D.C.

21. Signature of Funeral Service Licensee: Donald V Borgwardt
22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. LUNG CANCER WITH HEPATIC METASTASES — 6 mos

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
SENILE DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Peter M Schissler
29c. License number: D 22780
29d. Date signed *(Month, Day, Year)*: March 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Peter M. Schissler, M.D. 7500 Greenway Center Drive, #430 Greenbelt, Md. 20770

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 14 2001
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09433

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Gary Lloyd Roby

2. Data of Daath (Month, Day, Yaar): March 14, 2001

3. Tima of Death: 0335

4a. Facility Nama *(If not institution, giva straat and number)*: Shady Grove Adventist Hospital

4b. City, Town, or Locatlon of Death: Rockville

4c. County of Death: Montgomery

**Funeral Director**

5. Social Sacurity Number: 232-60-3684

6. Sax: 1 [X] M 2 [ ] F

7. Aga *(In yrs. last birthday)*: 62 Yrs.

If Undar 1 Yaar: Months / Days

If Undar 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Yaar)*: Mar. 10, 1939

9. Birthplaca *(Stata or Foraign Country)*: West Virginia

Usual Rasidance of Decadent

10a. Stata: Maryland

10b. County: Montgomery

10c. City, Town or Location: Germantown

10d. Insida City Limits: 1 [ ] Yas 2 [X] No

10e. Street and Number: 13124 Deer Path Lane

10f. Zip Coda: 20874

10g. Citizan of What Country?: United States

11. Marital Status: 1 [ ] Navar Marriad 2 [X] Marriad 3 [ ] Widowad 4 [ ] Divorcad

12. Was Decadent Evar in U.S. Armad Forcas? 1 [X] Yas 2 [ ] No If Yas, Giva Yaar or Datas: Vietnam

13. Was Decadent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 [ ] Yas 2 [X] No *Specify:*

14. Race - Amarican Indian, Black, White, atc. *Specify:* White

15. Decadent's Education *(Specify only highast grada complatad)*: Elamantary/Secondary (0-12): Collaga (1-4or 5+): 4

16a. Decadent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratirad)*: Computer Specialist

16b. Kind of Businass/Industry: U.S. Marshalls Office

17. Fathar's Nama *(First, Middla, Last)*: Harold Lloyd Roby

18. Mothar's Nama *(First, Middla, Maidan Sumama)*: Jessie Elizabeth Speelman

19a. Informant's Name/Ralationship *(Type, Print)*: Dolores Roby/Wife

19b. Mailing Addrass *(Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 13124 Deer Path Lane, Germantown, Maryland 20874

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar *(Specify)*

20b. Placa of Disposition *(Nama of camatary, crematory or othar placa)*: Arlington Nat'l Cemetery

Date: Mar 27 2001

20c. Location - City or Town, Stata: Arlington, Virginia

21. Signatura of Funaral Sarvica Licansa: Daniel E. Perry M00803

22. Nama and Addrass of Facility: Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805

**Physician /Medical Examiner**

23a. Part I. Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona ceusa on each lina.

Approximate Intarval Batwaan Onsat and Death

Immadiata Causa (Finel disaasa or condition rasulting in daath)

a. Metastatic Oat Cell Carcinoma of Right Lung — 5 Years

Due to (or as a consaquanca of):

Sequantially list conditions, if any, leading to immadiata causa. Entar Undarlying Causa (Diseasa or Injury that initiatad events rasulting in daath) Last

b.

Dua to (or as a consaquanca of):

c.

Dua to (or as a consaquanca of):

d.

Part II. **Othar significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No

24b. Wara autopsy findings available prior to completion of cause of daath? 1 [ ] Yas 2 [ ] No

25. Was casa rafarrad to medical axaminar? 1 [ ] Yas 2 [X] No

26. Placa of Death *(Check only ona)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Homa 5 [ ] Rasidance 8 [ ] Othar *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding invastigation 6 [ ] Could not be datarmined

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of Injury M

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Dascribe how injury occurred

28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*

28f. Location *(Streat and Number or Rural Route Number, City or Town, State)*

29a. Cartifier *(Check only one)*: 1 [X] **Certifying Physician**: To tha bast of my knowladga, daath occurrad at the time, data and placa, and dua to the causa(s) and manner as stated. 2 [ ] **Medical Examiner**: On tha basis of axamination and/or invastigation, in my opinion, death occurrad at the tima, data and placa, and due to the ceuse(s) and manner stated.

29b. Signatura and title of cartifier: James A. Brown M.D.

29c. Licansa number: D07285

29d. Data signed *(Month, Day, Yaar)*: March 15, 2001

30. Nama and addrass of parson who complatad cause of death (Item 23a) (Type, Print): James A. Brown, M.D. 9707 Medical Center Drive, Rockville, Maryland 20850

**State Registrar**

31. Data filad *(Month, Day, Yaar)*: MAR 16 2001

32. Registrar's Signatura: Irene G. Sparks

DHMH 16 Rev 6/95

---

**Baltimore, Maryland 21215-0020**

**Division of Vital Records, P.O. Box 68760,**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 6

**To Be Completed by Funeral Director**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. 10+1

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Amend #5,7,8,3/23/2001,BMW,Montg.Co.

# Certificate of Death

2001 09434
Reg. No.

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Nell M. Reed
2. Date of Death Month Day Year: March 13, 2001
3. Time of Death: 2030
4a. Facility Name *(If not institution, give street and number)*: Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 463-14-9920 ~~458-03-3553~~
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 84 Yrs. ~~78~~
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Aug 14, 1916 ~~1922~~
9. Birthplace *(State or Foreign Country)*: Texas

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5503 Namakagan Road
10f. Zip Code: Bethesda
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Personnel Officer
16b. Kind of Business/Industry: Federal Government

17. Father's Name *(First, Middle, Last)*: Joe Brent Powell, Jr.
18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Saunders

19a. Informant's Name/Relationship *(Type, Print)*: Melissa M. Hevenor/Niece
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3153 Clint Moore Road, #104, Boca Raton, FL 33496

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Parklawn Memorial Park
Date: Mar 18 2001
20c. Location - City or Town, State: Rockville, Maryland

21. Signature of Funeral Service Licensee: M00689
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Multiple injuries — one month
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

28. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*: Feb. 13, 2001
28b. Time of Injury: 3:00 p.m.
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: Motor vehicle accident
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: 5503 Namakatan Road, driveway
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: Glen Echo, Maryland

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and mannar as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: Patricia L. Tomsko, MD
29c. License number: D51916
29d. Date signed *(Month, Day, Year)*: March 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Patricia L. Tomsko, MD, 11140 Rockville Pike, PMB 348, Rockville, MD 20852

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 16 2001
32. Registrar's Signature: G. Sparks

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Reed Nell M 3/13/01 2030

35

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Amend #28a-f, 3/12/2001, BMW, Montg.Co.

# Certificate of Death

Reg. No. 2001 09435

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Patricia Anne Randall | March 9, 2001 | 3:10 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Suburban Hospital | Bethesda | Montgomery |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-28-1148 | 1☐ M 2☒ F | 70 Yrs. | | | Oct 18, 1930 | MD |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Montgomery | Kensington | 1☐ Yes 2☒ No |

| 10a. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 10011 Crestwood Road | 20895 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementery/Secondary (0-12) | College (1-4or 5+) | | |
| | 4 | Supervisor | Vitro Corporation |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| John Paul Randall | Ellen Campbell Riggs |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Nancy R. Rouse / Sister | 1305 Park Avenue, Baltimore, MD 21217 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Metropolitan Crematory | 3/12/01 | Alexandria, VA |

21. Signature of Funeral Service Licensee: ▶ Robert E. Ramey

22. Name and Address of Facility: Francis J. Collins Funeral Home, 500 University Blvd West, Silver Spring, MD 20901

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Cerebral Circulatory arrest | |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | b. Subarachnoid Hemorrage | |
| | Due to (or as a consequence of): | |
| | c. Intracranial aneurysm | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☒ No |

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| 3/4/01 | A.M. | 1☐ Yes 2☒ No | Subarachnoid Hemorrage |

28e. Place of Injury (Home; farm, street, factory, office building, etc.) (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(a) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ A. Powers | MD 43691 | 3/10/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): A. POWERS, 3 WASHINGTON CIRCLE, WASHINGTON DC 20037

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 13 2001 | ▶ Bruce G. Sparks |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Randall, Patricia 3/9/01 @1510

15

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar: Amended item#1 per MD FCHD, KS

Reg. No.: 2001 09436

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ~~Gene Austin Schultz Sr.~~ Gene Austin Shultz Sr.

2. Date of Death (Month, Day, Year): March 7, 2001

3. Time of Death: 10:18 p.m.

4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

**Funeral Director**

5. Social Security Number: 217-28-5133

6. Sex: 1 X M 2 F

7. Age (In yrs. last birthday): 69 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 16, 1931

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1 Yes 2 X No

10e. Street and Number: 9341 O'Possumtown Pike

10f. Zip Code: 21702

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 Never Married 2 Married 3 Widowed 4 X Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No. If Yes, Give Year or Dates: Korean

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Meat Cutter

18b. Kind of Business/Industry: Carmack Jay's

17. Father's Name (First, Middle, Last): Austin C. Shultz

18. Mother's Name (First, Middle, Maiden Surname): Katherine Irene Tobery

19a. Informant's Name/Relationship (Type, Print): Gene A. Shultz, Jr. (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8926 Indian Springs Road, Frederick, MD 21702

20a. Method of Disposition: 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Olivet Cemetery

Date: 3/12/01

20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: Robert E. Dailey Jr

22. Name and Address of Facility: ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia — Approximate Interval: 6 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Cirhosis of liver — Approximate Interval: 5 yr

Due to (or as a consequence of):

c. Renal failure — Approximate Interval: 6 days

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy: 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown

23d. Date of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 X No

26. Place of Death (Check only one): Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA; Other: 4 Nursing Home 5 Residence 8 Other (Specify)

27. Manner of Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: R Robert S. Hughes

29c. License number: DO 5111

29d. Date signed (Month, Day, Year): March 8, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert S. Hughes, MD 700 Montclaire Avenue, Frederick, Maryland 21701

**State Registrar**

31. Date filed (Month, Day, Year): MAR 12 2001

32. Registrar's Signature: Donna B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at this

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09437

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Anne Sustrick
2. Date of Death: Month / Day / Year: 2-28-2001
3. Time of Death: 4:30 P.M
4a. Facility Name *(If not institution, give street and number)*: Holy Cross Rehab Center
4b. City, Town, or Location of Death: Burtonsville
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 523-07-2943
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 07-07-1910
9. Birthplace *(State or Foreign Country)*: Colorado

Usual Residence of Decedent

10a. State: MD.
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 9039 Sligo Creek PKWY. #502
10f. Zip Code: 20910
10g. Citizen of What Country?: U.S.A

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yas 2☒ No *Specify:*
14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12) / College (1-4or 5+): 4yrs.
16a. Decedent's Usual Occupation *(Giva kind of work done during most of working life. DO NOT usa ratired)*: Technical Writer Supervisor
16b. Kind of Business/Industry: Dept. Of Navy

17. Father's Name *(First, Middle, Last)*: Joseph Sustrick
18. Mother's Name *(First, Middle, Meiden Surnema)*: Johanna Lochnikar

19a. Informant's Name/Relationship *(Type, Print)*: Daniel Sustrick(Brother)
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 9209 Grandview Dr. Overland Park. Kansas 66212

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Othar *(Specify)*
20b. Place of Disposition *(Neme of cemetary, cremetory or other piece)*: Georgetown Medical School
Date: 2-28-01
20c. Location - City or Town, State: Washington D.C.

21. Signature of Funerel Service Licensee: [signature]
22. Name and Address of Facility: Austin Royster Funeral Home 3821 14th ST. N.W. Washington D.C.

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or raspiratory errast, shock, or haart failura. List only one ceusa on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Advanced Bladder Carcinoma
Due to (or as a consequence of):
b. Hypertension

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or injury that initiated events resulting in death) Last
Dua to (or as a consequence of):
c. Anemia
Due to (or as a consequence of):
d. C.H.F.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hydronephroism

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: ☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, straet, factory, office building, etc. *(Specify)*
28f. Location *(Straet end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, dete and piece, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, end due to the cause(s) end manner stated.

29b. Signature and title of certifier: Kirti Vohra M.D
29c. License number: D-20274
29d. Date signed *(Month, Day, Year)*: 2-28-01

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): 7710 Bradley BLVD, Bethesda, MD 20817 Kirti Vohra, M.D.

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 13 2001
32. Registrar's Signature: [signature]

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

2/9

DHMH 16 Rev 6/95

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09438

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Donald Stanley Sullivan
2. Date of Death (Month, Day, Year): March 12, 2001
3. Time of Death: 11:14 pm
4a. Facility Name (If not institution, give street and number): 3355 University Blvd., #207
4b. City, Town, or Location of Death: Kensington
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 578-70-8311
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 47 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 17, 1953
9. Birthplace (State or Foreign Country): DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Kensington
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 3355 University Blvd., #207
10f. Zip Code: 20895
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Painting Contractor
16b. Kind of Business/Industry: Own Business

17. Father's Name (First, Middle, Last): William Sullivan
18. Mother's Name (First, Middle, Maiden Surname): Lillie Salmon

19a. Informant's Name/Relationship (Type, Print): Margaret Mary Sullivan/ Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3355 University Blvd., #207, Kensington, MD 20895

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Hill Cemetery
Date: Mar 16 2001
20c. Location - City or Town, State: Suitland, MD

21. Signature of Funeral Service Licensee: J. Keir Skeles
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Liver Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Cirrohis of Liver

Due to (or as a consequence of):

c. Hepatitis C

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: William E Legat MD
29c. License number: D 11085
29d. Date signed (Month, Day, Year): March 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William E. Legat, M.D. 5812 Plainview Road Bethesda, MD 20817

**State Registrar**

31. Date filed (Month, Day, Year): MAR 16 2001
32. Registrar's Signature: Donna G. Sparks

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Amend #16a,3/21/2001,BMW,Montg.Co. *Certificate of Death* Reg. No. 2001 09439

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): John Stegmaier

2. Data of Death: Month Mar. Day 10, Year 2001

3. Time of Death: 8:40 PM.

4a. Facility Name (If not institution, give street and number): Suburban Hospital

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 020-09-9915

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): Jul. 13, 1915

9. Birthplace (State or Foreign Country): Massachusetts

Usual Residence of Decedant

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Kensington, [illegible]

10d. Inside City Limits: 1 [ ] Yas 2 [X] No

10e. Street and Number: 3205 Wake Drive

10f. Zip Coda: 20895

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Nevar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1 [X] Yas 2 [ ] No If Yas, Giva Yaar or Datas: WW11

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 [ ] Yas 2 [X] No Specify:

14. Race - American Indian, Black, White, atc. Specify: White

15. Decedant's Education (Specify only highast grada complatad): Elementary/Secondary (0-12): | College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratirad): Foreign ~~Services~~ Service Officer

16b. Kind of Businass/Industry: U.S. State Department

17. Fathar's Nama (First, Middla, Last): Carl Stegmaier

18. Mother's Nama (First, Middla, Maidan Sumama): Charlotte Perkins

19a. Informant's Name/Reletionship (Type, Print): Daphne S. Stegmaier _ Wife

19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda): 3205 Wake Drive, Kensington, Md. 20895

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cramation 3 [ ] Removal from Stata 4 [ ] Donation 5 [ ] Othar (Specify)

20b. Placa of Disposition (Nama of cematary, cramatory or othar placa): National Crematory | Data: 3/15/01

20c. Location - City or Town, Stata: Falls Church, Va.

21. Signatura of Funaral Sarvica Licensaa: Thomas E Hoxbaker

22. Nama and Addrass of Facility: Joseph Gawler's Sons, inc. 5130 Wisc. Ave. NW., Washington, D.C. 20016

**Physician /Medical Examiner**

23a. Part1. Entar tha disaasa, or complications that causad tha daath. Do not antar the moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximate Intarval Between Onsat and Daath

Immediata Cause (Final disaasa or condition rasulting in death):
a. Septic Shock — 2 Weeks

Dua to (or as a consaquance of):
b. Sepsis — 3 Weeks

Sequentially list conditions, if any, leading to immediata causa. Entar Underlying Cause (Disease or Injury that initiated evants rasulting in death) Last
Dua to (or as a consaquance of):
c. Pneumonia — 4 Weeks

Dua to (or as a consaquance of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa givan in Part I.

Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yas 2 [ ] No

24b. Wara autopsy findings available prior to completion of cause of death? 1 [ ] Yas 2 [X] No

25. Was casa refarrad to medical examinar? 1 [ ] Yas 2 [X] No

26. Placa of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Homa 5 [ ] Residence 6 [ ] Othar (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Data of Injury (Month, Day Year)

28b. Tima of Injury

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, straat, factory, offica building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Cartifier (Check only one): 1 [X] **Certifying Physician**: To tha best of my knowledga, daath occurrad at tha time, data and placa, and due to the cause(s) and mannar as stated. 2 [ ] **Medical Examiner**: On tha basis of examinetion and/or investigetion, in my opinion, death occurrad at tha tima, data and placa, and dua to tha cause(s) and mannar steted.

29b. Signatura and titla of cartifiar: Dina Darwish, M.D.

29c. Licansa number: D50283

29d. Data signed (Month, Day, Year): March 13, 2001

30. Name and addrass of parson who complatad causa of death (Item 23a) (Type, Print): DINA DARWISH, MD. 3835 Farragut Ave. Kensington, Md. 20895

**State Registrar**

31. Data filed (Month, Day, Year): MAR 15 2001

32. Registrar's Signatura: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Stegmaier, John 3/10/01 @ 2040

12

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09440

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Edith C. Spencer
2. Date of Death (Month, Day, Year): March 12, 2001
3. Time of Death: 8:30 AM
4a. Facility Name (If not institution, give street and number): Crofton Convalescent Center
4b. City, Town, or Location of Death: Croften
4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 234-62-3207
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 60 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 14, 1940
9. Birthplace (State or Foreign Country): Hewett, WV

Usual Residence of Decedent

10a. State: MD
10b. County: Prince George's
10c. City, Town or Location: Bowie
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 12906 Clearfield Drive
10f. Zip Code: 20715
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☐ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Cebert Ellis
18. Mother's Name (First, Middle, Maiden Surname): Gaynell Nay

19a. Informant's Name/Relationship (Type, Print): Rhonda Kendrick-Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12906 Clearfield Dr. Bowie, MD 20715

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Wallen Cemetery
Date: 3/15/01
20c. Location - City or Town, State: Hewett, WV

21. Signature of Funeral Service Licensee: ▶ Dennis A. Coleman
22. Name and Address of Facility: Metropolitan Funeral Service 5517 Vine Street. Alexandria, VA 22310

GF

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0020**

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Dementia — 2 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Howard K Schultz Jr
29c. License number: D35848
29d. Date signed (Month, Day, Year): Mar. 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Howard K Schultz Jr 1438 Defense Hwy Gambrills MD 21054

**State Registrar**

31. Date filed (Month, Day, Year): MAR 14 2001
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2001 09441

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Kermith Higgs Speierman
2. Date of Death Month Day Year: March 11, 2001
3. Time of Death: 2:37 am
4a. Facility Name *(If not institution, give street and number)*: 2412 Parallel Lane
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 572-28-5441
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 72 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: April 19, 1928
9. Birthplace *(State or Foreign Country)*: California

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2412 Parallel Lane
10f. Zip Code: 20904
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: Uknown
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Mathematician
16b. Kind of Business/Industry: NSA

17. Father's Name *(First, Middle, Last)*: Charles Wallace Speierman
18. Mother's Name *(First, Middle, Maiden Surname)*: Delilah Higgs

19a. Informant's Name/Relationship *(Type, Print)*: Doris M. Speierman - Spouse
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2412 Parallel Lane, Silver Spring, Maryland 20904

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Columbia Memorial Park
Date: 3-14-01
20c. Location - City or Town, State: Columbia, Maryland

21. Signature of Funeral Service Licensee: Donald E. Smith
22. Name and Address of Facility: Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Gall Bladder Cancer — 1 Year
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Frederick G. Barr MD
29c. License number: D22775
29d. Date signed *(Month, Day, Year)*: March 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Frederick G. Barr, M.D. 5454 Wisconsin Ave., #1345, Chevy Chase, Maryland 20815

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 15 2001
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 09442

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Maria Mary Soroka | March 11, 2001 | 3:41 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Holy Cross Hospital | Silver Spring | Montgomery |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 517-54-0302 | 1☐M 2☒F | 86 Yrs. | | | Jan 20, 1915 | Poland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Prince George's | Hyattsville | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 7300 18th Avenue, Apt 206 | 20783 | Poland |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 4 | | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Unknown Zawoda | Unknown |

| 19a. Informent's Neme/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Jerry Soroka / Son | 3727 Thornwood Road, Landover Hills, MD 20784 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, cremetory or other piece) | Date | 20c. Location - City or Town, Steta |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Cedar Hill Cemetery | March 14 2001 | Suitland, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Jeffrey L. Smith | Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

28a. Part I. Enter the disease, or complications that caused tha death. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heart failure. List only ona cause on each line.

| | | Approximata Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Finel diseese or condition resulting in death) | a. Sepsis | |
| Sequentlelly list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in daath) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as e consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause ol death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24e. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☒No |

| 25. Wes casa referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2☐Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Yeer) |
|---|---|---|
| ▶ G. Chablani | D 42518 | March 11, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Gul Chablani, MD 11119 Rockville Pike, Suite 316, Rockville, MD 20852

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 12 2001 | Donna B. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attanding Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09443

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): HANNAH SOORENKO

2. Date of Death (Month, Dey, Yaar): MARCH 8, 2001

3. Time of Death: 7:30 AM

4a. Facility Name (If not institution, give street end number): 3005 SOUTH LEISURE WORLD BLVD #102

4b. City, Town, or Location of Deeth: SILVER SPRING

4c. County of Death: MONTGOMERY

**Funeral Director**

5. Social Security Number: 197-16-5032

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. lest birthday): 74 Yrs.

If Under 1 Yaar: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Dey, Yeer): JULY 21, 1926

9. Birthplaca (State or Foreign Country): PENNSYLVANIA

Usuet Residence of Decedent

10e. State: MD

10b. County: MONTGOMERY

10c. City, Town or Location: SILVER SPRING

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3005 SOUTH LEISURE WORLD BLVD #102

10f. Zip Code: 20906

10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Datas:

13. Was Decedent of Hispenic Origin? (Specity Yas or No- If Yes, specity Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highast grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

18a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired): ADMINISTRATIVE ASSISTANT

16b. Kind of Business/Industry: US GOVERNMENT

17. Father's Name (First, Middle, Last): HARRY BENN

18. Mother's Name (First, Middle, Maiden Surname): SARAH LEVINE

19e. Informant's Name/Relationship (Type, Print): BARRY SOORENKO/SON

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 1380 CANTERBURY WAY, ROCKVILLE, MARYLAND 20854

20a. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other pleca): PARKLAWN/MENORAH GARDENS

Date: MARCH 12, 2001

20c. Location - City or Town, State: ROCKVILLE, MARYLAND

21. Signature of Funeral Service licensee: [signature]

22. Nama and Address of Feclity: EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiec or respiratory arrast, shock, or haart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseesa or condition resulting in deeth) a. Cancer of pancreas — 1 year

Due to (or as e consequence of):

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury thet initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or es a consequence of):

d.

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yas 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findinga available prior to completion of ceusa of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Othar (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be datarmined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Straat and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and manner as stated. 2☐ **Medcal Examiner:** On tha basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D09834

29d. Data signed (Month, Dey, Yeer): 3/8/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BARRY ROSENBAUM 3720 FARRAGUT AVE. KENSINGTON, MD 20895

**State Registrar**

31. Date filed (Month, Day, Year): MAR 13 2001

32. Registrer's Signature: [signature] B. Sparks

DHMH 16 Rev 6/95

---

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic avant, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09444

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: NORMA JEAN SOFRANKO
2. Date of Death Month / Day / Year: MARCH 7, 2001
3. Time of Death: 4:30 P.M.
4a. Facility Name *(If not institution, give street and number)*: 812 CLIFTONBROOK LANE
4b. City, Town, or Location of Death: SILVER SPRING
4c. County of Death: MONTGOMERY

**Funeral Director**

5. Social Security Number: 579-40-5400
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 69 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: SEP. 16, 1931
9. Birthplace *(State or Foreign Country)*: MICHIGAN

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: MONTGOMERY
10c. City, Town or Location: SILVER SPRING
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 812 CLIFTONBROOK LANE
10f. Zip Code: 20905
10g. Citizen of What Country?: UNITED STATES OF AMERICA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12); College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SECRETARY
16b. Kind of Business/Industry: INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS

17. Father's Name *(First, Middle, Last)*: OWEN B. MADISON
18. Mother's Name *(First, Middle, Maiden Surname)*: AGNES PHILLIPS

19a. Informant's Name/Relationship *(Type, Print)*: MICHAEL F. SOFRANKO (HUSBAND)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 812 CLIFTONBROOK LANE; SILVER SPRING, MARYLAND 20905

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: FORT LINCOLN CEMETERY
Date: MAR. 13, 2001
20c. Location - City or Town, State: BRENTWOOD, MARYLAND

21. Signature of Funeral Service Licensee: James B. Schwartz.
22. Name and Address of Facility: HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVEUNE SILVER SPRING, MARYLAND 20904-2891

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Gastrointestinal bleeding — months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Malnutrition

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Patricia L. Tomsko, MD
29c. License number: D51916
29d. Date signed *(Month, Day, Year)*: March 7, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Patricia L. Tomsko, MD 11140 Rockville Pike, #348, Rockville, MD 20852

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 15 2001
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

10

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09445

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Leslie E. Smith ,Sr.

2. Date of Death (Month, Day, Year): March 9, 2001

3. Time of Death: 8:05 am

4a. Facility Name (If not institution, give street and number): 7538 Cherry Tree Drive

4b. City, Town, or Location of Death: Fulton

4c. County of Death: Howard

**Funeral Director**

5. Social Security Number: 578-20-9482

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

6. Date of Birth (Month, Day, Year): June 16, 1920

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Fulton

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 7538 Cherry Tree Drive

10f. Zip Code: 20759

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1942-1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Firefighter(Lieutenant)

16b. Kind of Business/Industry: DC Fire Department

17. Father's Name (First, Middle, Last): Ollie J. Smith

18. Mother's Name (First, Middle, Maiden Surname): Bessie May Cropp

19a. Informant's Name/Relationship (Type, Print): Anna D. Smith / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7538 Cherry Tree Drive, Fulton, MD 20759

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Norbeck Memorial Park

Date: Mar 12 2001

20c. Location - City or Town, State: Olney, MD

21. Signature of Funeral Service Licensee: Anne Marie Parker

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Alzheimer's Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Depression

Parkinson's Disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: E. K. Shaw

29c. License number: D25947

29d. Date signed (Month, Day, Year): August 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Evan J. Shaw, MD 3416 Olney-Sandy Spring Road, Suite 200, Olney, MD 20832

**State Registrar**

31. Date filed (Month, Day, Year): MAR 13 2001

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

10+1

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2001 09446

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Charles Elmer Smith
2. Date of Death (Month, Day, Year): March 12, 2001
3. Time of Death: 9:15 AM

4a. Facility Name *(If not institution, give street and number)*: 15101 Interlachen Drive #721
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 295-16-3824
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Oct. 5, 1915
9. Birthplace *(State or Foreign Country)*: Ohio

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 15101 Interlachen Drive #721
10f. Zip Code: 20906
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Club Manager
16b. Kind of Business/Industry: Country Club

17. Father's Name *(First, Middle, Last)*: Frank Rite Smith
18. Mother's Name *(First, Middle, Maiden Surname)*: Nellie B. Matheny

19a. Informant's Name/Relationship *(Type, Print)*: Craig M. Smith/Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 403 Arctic Avenue, Ocean City, Maryland 21842

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Montgomery Crematorium, Inc. | Date: March 14, 2001
20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: ▶ Ray Lee M00198
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Coronary Artery Disease — Immediate

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD
29c. License number: D18721
29d. Date signed *(Month, Day, Year)*: March 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Arthur Schoengold, M.D. 18111 Prince Philip Drive, Olney, Maryland 20832

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 16 2001
32. Registrar's Signature: ▶ B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 6

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

20+1

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

Amend #18,3/13/2001,BMW,Montg.Co.
Amend #11,20b,3/13/2001,BMW,Montg.Co.

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09447

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Alfonso Spencer Small Jr.

2. Date of Death Month Day Year: 3-5-2001

3. Time of Death: 5:07A.M.

4a. Facility Name (If not institution, give street and number): Holy Cross Hospital

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 578-22-1513

6. Sex: 1☐M 2☐F — X

7. Age (In yrs. last birthday): 75yrs. Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 04-13-1925

9. Birthplace (State or Foreign Country): Washington,DC

Usual Residence of Decedent

10a. State: MD

10b. County: Oxon Hill(P.G.)

10c. City, Town or Location: Oxon Hill

10d. Inside City Limits: 1☐Yes 2☐No — X

10e. Street and Number: 4729 Summertime Dr.

10f. Zip Code: 20745

10g. Citizen of What Country?: U.S.

11. Marital Status: ~~1☐Never Married~~ 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☐No — X
If Yes, Give Year or Dates: Navy

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1☐Yes 2☒No — X Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th Grade
College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Driver

16b. Kind of Business/Industry: Sanford GreenburgAssoc

17. Father's Name (First, Middle, Last): Alfonso Spencer Small Sr.

18. Mother's Name (First, Middle, Maiden Surname): Cecelia O. ~~Swearinger~~ Satterfield

19a. Informant's Name/Relationship (Type, Print): Betty Jean Small(wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4729 Summertime Drive OxonHill,MD 20745

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Fort Lincoln Cemetery

Date: 3/19/01 ~~March 19 01~~

20c. Location - City or Town, State: Brentwood,MD

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: Austin Royster Funeral Home
3821 14th St,N.W. Washington, DC 20011

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Respiratory Failure

Due to (or as a consequence of):
Aspiration Pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes

Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No — X 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No — X

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No — X

25. Was case referred to medical examiner? 1☐Yes 2☒No — X

26. Place of Death (Check only one)
Hospital: 1☒Inpatient — X 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural — X 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. — X
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D0056219

29d. Date signed (Month, Day, Year): 03-05-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Katarzy Ostrzenskamo 2304 Shorefield Rd. Silver Spring, MD 20902

**State Registrar**

31. Date filed (Month, Day, Year): MAR 19 2001

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09448

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Elizabeth G. Shilling
2. Date of Death (Month, Day, Year): March 7, 2001
3. Time of Death: 4:30 pm
4a. Facility Name (If not institution, give street and number): 12129 Livingston Street
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 577-26-6334
6. Sex: 1☐ M 2☒ F
7. Age (in yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 12, 1923
9. Birthplace (State or Foreign Country): DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 12129 Livingston Street
10f. Zip Code: 20902
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): John Gilmore
18. Mother's Name (First, Middle, Maiden Surname): Mabel Duvall

19a. Interment's Name/Relationship (Type, Print): Kenneth Shilling, Jr. / Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 110 Paradise Avenue, Mt. Airy, MD 21771

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery
Date: March12 2001
20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: Scott L. Samuel
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Respiratory Failure | month |
| Due to (or as a consequence of): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. | Chronic Obstructive Lung Disease | years |
| Due to (or as a consequence of): | | |
| c. | Cor Pulmonale | years |
| Due to (or as a consequence of): | | |
| d. | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Irnest S. Oser
29c. License number: D 03792
29d. Date signed (Month, Day, Year): March 8, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Irnest S. Oser, MD 10301 Georgia Ave., Suite 304, Silver Spring, MD

**State Registrar**

31. Date filed (Month, Day, Year): MAR 12 2001
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend #31, see #32, BMW, Montg.Co. 3/16/2001
Amend #28a, 3/16/2001, BMW, Montg.Co.

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09449

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): SAMUEL ANTONUIS SHEEHI
2. Date of Death: Month MARCH Day 12 Year 2001
3. Time of Death: 1850
4a. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

**Funeral Director**

5. Social Security Number: 577-24-1575
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Apr 18, 1922
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 11120 Arroyo Drive
10f. Zip Code: 20852
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: Unknown
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Electrical Engineer
16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): Joseph Sheehi
18. Mother's Name (First, Middle, Maiden Surname): Selma Starr

19a. Informant's Name/Relationship (Type, Print): Nancy S. Kelly / Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11120 Arroyo Drive, Rockville, MD 20852

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery | Date: Mar 16 2001
20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: ▶ Robert E. Ramsey
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Silver Spring, MD 20901

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. MULTI ORGAN FAILURE — FEW HOURS
Due to (or as a consequence of):
b. RESPIRATORY FAILURE — MINUTES
Due to (or as a consequence of):
c. PNEUMONIA
Due to (or as a consequence of):
d. ANEMIA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year): N/A
28b. Time of Injury: M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ V. Thekkumthala M.D.
29c. License number: D0051158
29d. Date signed (Month, Day, Year): 3/12/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): VATH T. ANTHY 2401 Research Blvd., Suite 102, Rockville, MD

**State Registrar**

31. Date filed (Month, Day, Year): ~~3/14/01~~ MAR 16 2001 in
32. Registrar's Signature: ▶ Geneva B. Sparks MAR 16 2001 Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg No 2001 09450

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Marion Theresa Sausville
2. Date of Death Month Day Year: March 5, 2001
3. Time of Death: 325am
4a. Facility Name *(If not institution, give street and number)*: Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 134-09-5029
6. Sex: 1☐ M 2☐ F
7. Age *(In yrs. last birthday)*: 81 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jul 25, 1919
9. Birthplace *(State or Foreign Country)*: NY

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☐ No
10e. Street and Number: 2109 Belvedere Blvd. #3
10f. Zip Code: 20906
10g. Citizen of What Country?: United States

11. Meritel Stetus: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12); College (1-4or 5+): 4
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Teacher
16b. Kind of Business/Industry: Education

17. Father's Name *(First, Middle, Last)*: Edward Sausville
18. Mother's Neme *(First, Middle, Meiden Surname)*: Georgiana Goes

19e. Informent's Neme/Relationship *(Type, Pnint)*: Edward Sausville /Nephew
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 709 Bonifant Rd, Silver Spring, MD 20905

20a. Method of Disposition: 1☐ Burlat 2☐ Cremetion 3☐ Removal from Stete 4☒ Donetion 5☐ Other *(Specify)*
20b. Plece of Disposition *(Neme of cemetery, crematory or other piece)*: USUHS — Dete: Mar 5 2001
20c. Location - City or Town, State: Bethesda, MD

21. Signeture of Funerel Service Licensee: Beverly L. Hewlette
22. Neme end Address of Fecility: Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, MD

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart tailure. List only one ceuse on eech line. — Approximete Interval Between Onset and Death

Immedlete Cause (Finel disease or condition resulting in death): a. Sepis — 4 days
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury thet initiated events resulting in death) Last: b. Diaphragmatic Hernia
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
28. Place of Deeth *(Check only one)*: Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Othar *(Specify)*

27. Menner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28e. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Phyalcian:** To the best of my knowledge, death occurred at tha time, dete and place, end due to the cause(s) and menner as stated. 2☐ **Medicat Examiner:** On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted.

29b. Signature and title of certifier: [signature]
29c. License number: D29675
29d. Date signed *(Month, Day, Year)*: MAR 5, 2001

30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print): Ralph Boccia M.D. 9707 Medical Center Dr. #300, Rockville, MD 20852

**State Registrar**

31. Dete filed *(Month, Dey, Year)*: MAR 13 2001
32. Registrer's Signeture: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09451

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: STEPHEN D. SALYER

2. Date of Death Month / Day / Year: MARCH 8, 2001

3. Time of Death: 16:16

4a. Facility Name *(If not institution, give street and number)*: HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death: SILVER SPRING

4c. County of Death: MONTGOMERY

**Funeral Director**

5. Social Security Number: 577.60.9619

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 54 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 05.11.1946

9. Birthplace *(State or Foreign Country)*: WASHINGTON, DC

Usual Residence of Decedent

10a. State: MD

10b. County: MONTGOMERY

10c. City, Town or Location: SILVER SPRING

10d. Inside City Limits: ☒ 1 Yes 2☐ No

10e. Street and Number: 2107 WINDHAM PLACE

10f. Zip Code: 20902

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) | College (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: TEACHER

16b. Kind of Business/Industry: EDUCATION

17. Father's Name *(First, Middle, Last)*: LLOYD SALYER

18. Mother's Name *(First, Middle, Maiden Surname)*: LOIS NORTHROP

19a. Informant's Name/Relationship *(Type, Print)*: TRACEY DORFMANN - WIFE

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2107 WINDHAM PLACE, SILVER SPRING, MARYLAND 20902

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: GARDEN OF REMEMBRANCE | Date: MAR 11, 2001

20c. Location - City or Town, State: CLARKESBURG, MARYLAND

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. VENTRICULAR FIBRILATION

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D0022932

29d. Date signed *(Month, Day, Year)*: 03-08-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANDREW MUCHMORE, MD 1500 FOREST GLEN RD, SILVER SPRING, MD 20910

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 13 2001

32. Registrar's Signature: [signature] S. Sparks

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

DHMH 16 Rev 6/95

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09452

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): BLANCHE F. SACRISON
2. Date of Death (Month, Day, Year): MARCH 9, 2001
3. Time of Death: 10:30 AM

4a. Facility Name (If not institution, give street and number): POTOMAC VALLEY NURSING CENTER
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

**Funeral Director**

5. Social Security Number: 517 03 1623
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 94 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JUNE 19, 1906
9. Birthplace (State or Foreign Country): MONTANA

Usual Residence of Decedent

10a. State: MD.
10b. County: MONTGOMERY
10c. City, Town or Location: OLNEY
10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 4005 LAYTONSVILLE ROAD
10f. Zip Code: 20832
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): WAITRESS
16b. Kind of Business/Industry: RESTAURANT

17. Father's Name (First, Middle, Last): HOMER PILON
18. Mother's Name (First, Middle, Maiden Surname): MARTHA RHINO

19a. Informant's Name/Relationship (Type, Print): THELMA M. ENGLER DAUGHTER-IN-LAW
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4005 LAYTONSVILLE ROAD, OLNEY, MD. 20832

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ARLINGTON NAT'L CEMETERY
Date: 3/15/01
20c. Location - City or Town, State: ARLINGTON, VA.

21. Signature of Funeral Service Licensee: ▶ Muriel H. Barber
22. Name and Address of Facility: MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Congestive Heart failure. — years
Due to (or as a consequence of):
b. Coronary heart disease — years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: D0050987
29d. Date signed (Month, Day, Year): 3/10/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ahmed Nawaz 1299 Lamberton drive Silver Spring MD 20902

**State Registrar**

31. Date filed (Month, Day, Year): MAR 13 2001
32. Registrar's Signature: ▶ Jenna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 09453

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: HADLEY PHILLIP TREMAINE

2. Date of Death (Month, Day, Year): March 11 2001

3. Time of Death: 3:37pm

4a. Facility Name *(If not institution, give street and number)*: Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

**Funeral Director**

5. Social Security Number: 150-30-9711

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 61 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Apr. 21, 1939

9. Birthplace *(State or Foreign Country)*: New Jersey

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Thurmont

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 16147 Eylers Valley Road

10f. Zip Code: 21788

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1 [ ] Yas 2 [X] No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 8; College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work dona during most of working life. DO NOT use retired)*: Professor

16b. Kind of Business/Industry: College

17. Fathar's Nema *(First, Middle, Last)*: Hadley E. Tremaine

18. Mother's Neme *(First, Middle, Meiden Sumema)*: Mildred Geffken

19a. Informant's Neme/Reletionship *(Type, Print)*: Susan G. Tremaine (Wife)

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 16147 Eylers Valley Road, Thurmont, Maryland 21788

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremetion 3 [ ] Removal from Stete 4 [ ] Donation 5 [ ] Othar *(Specify)*

20b. Piece of Disposition *(Neme of camatery, cremetory or other piece)*: Smithsburg Crematory

Dete: 3/12/01

20c. Location - City or Town, State: Smithsburg, Maryland

21. Signature of Funeral Service Licensee: Robert Dailey Jr

22. Nema end Address of Fecility: ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 EAST MAIN STREET, THURMONT, MD 21788

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel diseese or condition resulting in death)

a. A.S.C.V.D. — Years

Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last

b.

Due to (or as e consequence of):

c.

Dua to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Piece of Death *(Check only one)*: Hospitel: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Othar: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end piece, end due to the cause(s) and manner es stated. 2 [X] **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: Andrew Zarick MD

29c. Licensa number: D35164

29d. Date signed *(Month, Day, Year)*: March 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Andrew Zarick, MD Rt. 40 1080 West Patrick Street, Frederick, Maryland 21704

**State Registrar**

31. Dete filed *(Month, Day, Year)*: MAR 13 2001

32. Registrar's Signature: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09454

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Emma Patricia Coyle Thomas
2. Date of Death (Month, Day, Year): Mar. 12, 2001
3. Time of Death: 12:02 AM

4a. Facility Name (If not institution, give street and number): 8510 Rosebud Ct.
4b. City, Town, or Location of Death: Middletown
4c. County of Death: Frederick

**Funeral Director**

5. Social Security Number: 203-16-9383
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 75 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 17, 1926
9. Birthplace (State or Foreign Country): PA.

Usual Residence of Decedent

10a. State: MD.
10b. County: Frederick
10c. City, Town or Location: Middletown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8510 Rosebud Ct.
10f. Zip Code: 21769
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 3
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): nurse
16b. Kind of Business/Industry: hospital

17. Father's Name (First, Middle, Last): Stuart Coyle
18. Mother's Name (First, Middle, Maiden Surname): Claire Zimmell

19a. Interment's Name/Relationship (Type, Print): Sarah J. Stockland (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8510 Rosebud Ct., Middletown, MD. 21769

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. John's Catholic Cemetery
Date: 3/15
20c. Location - City or Town, State: Coylestown, PA.

21. Signature of Funeral Service Licensee: Donald B Thompson
22. Name and Address of Facility: Donald B. Thompson Funeral Home 31 E. Main St., Middletown, MD. 21769

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Cerebral edema | 7d |
| Due to (or as a consequence of): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. | Glioblastoma multiforme | 3 mo |
| Due to (or as a consequence of): | | |
| c. | | |
| Due to (or as a consequence of): | | |
| d. | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Anemia, Diabetes mellitus, Parkinsons, ASCVD

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D14C12C
29d. Date signed (Month, Day, Year): May 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): D G Jones 501 W 7th St Frederick MD

**State Registrar**

31. Date filed (Month, Day, Year): MAR 13 2001
32. Registrar's Signature: Donna B Sparks

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 16 Rev 6/95

ORIGINAL

01-1285-005
CLYDA TUTCHTON
JVW

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

2001 09455
Reg. No.

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|
| Clyda Naomi Tutchton | MARCH 07, 2001 | 10:50 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 3227 VULCAN ROAD | DUNDALK | BALTIMORE |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-26-9861 | 1☐M 2☒F | 74 Yrs. | | | Feb. 4, 1927 | West Virginia |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Baltimore | Dundalk | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3227 Vulcan Rd | 21222 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Bookkeeper | Accounting |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| (Unknown) Grogg | (Unknown) |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Scott Tutchton / son | 109 Longnail Rd., Timonium, MD 21093-3340 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Chesapeake Crematory | 3/13/2001 | Beltsville, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Stephen D. Lohrmann M00382 | CAFA Stephen D. Lohrmann, P.A. 8717 Green Pastures Dr. Towson, MD 21286 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Hypertensive Arteriosclerotic Cardiovascular Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Diabetes Mellitus

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☒Yes 2☐No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) SCENE |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ J Pestaner M.D. | O.C.M.E. | MARCH 08, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 13 2001 | B. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09456

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|
| Fannie | Tossman | March 15, 2001 | 6:10A. |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Hebrew Home of Greater Washington | Rockville | Montgomery |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-09-4594 | 1☐ M 2☒ F | 85 Yrs. | | | April 5, 1915 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Montgomery | Olney | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 4613 Prestwood Drive | 20832 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Rece - American Indien, Bleck, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Datas: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Sales | Retail |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| David Levin | Lena Heghkin |

| 19a. Interment's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Howard Tossman - son | same as #10 a - 10 g |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donation 5☐ Other (Specify) | Mt. Lebanon Cemetery | 3/16/2001 | Adelphi, Maryland |

21. Signature of Funeral Service Licensee: [signature]

22. Neme end Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. CEREBRAL THROMBOSIS | |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | b. | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Wes an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: ☒ 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] M.D. | D 18084 | MARCH 15, 2001 |

30. Name end address of parson who completed cause of deeth (Item 23e) (Type, Print): D. D. PATEL, M.D. 6121 MONTROSE RD, ROCKVILLE, MD 20852

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 16 2001 | [signature] B. Sparks |

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09457

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Bertha Aucona Torres
2. Date of Death (Month, Day, Year): March 7, 2001
3. Time of Death: 12:18Am
4a. Facility Name (If not institution, give street and number): Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 577-94-3782
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sep 15, 1917
9. Birthplace (State or Foreign Country): Mexico

Usual Residence of Decedent

10a. State: MD
10b. County: Prince George's
10c. City, Town or Location: Adelphi
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1801 Metzerott Rd.
10f. Zip Code: 20783
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☒ Yes 2☐ No Specify: Mexican
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Sostenes Aucona Perez
18. Mother's Name (First, Middle, Maiden Surname): Petrona Araujo

19a. Informant's Name/Relationship (Type, Print): Edda Osborne /Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6603 Wells Parkway, University Park, MD 20782

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory | Date: Mar 10 2001
20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: Stephen E. Lohmann
22. Name and Address of Facility: Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, MD

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. MYOCARDIAL INFARCTION — 2 HOURS.

Due to (or as a consequence of):
b. CONGESTIVE HEART FAILURE — 2 HOURS.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Dan M Sobel MD DME 3/12/01

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

- FRACTURE RIGHT PELVIC BONE AND ACETABULUM
- DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year): 3.3.01
28b. Time of Injury: 2:8 P.M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how Injury occurred: PRESUMED TO HAVE FALLEN IN NURSING HOME
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): NURSING HOME: HCR MANOR CARE
28f. Location (Street and Number or Rural Route Number, City or Town, State): 1810 METZEROTT ROAD, ADELPHI MD 20783

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: R. Shyamsundar MD
29c. License number: D0053367
29d. Date signed (Month, Day, Year): 3.8.01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAJAN SHYAMSUNDAR, M.D. 10810, PARKTOWN ROAD, SUITE 202, GAITHERSBURG, MD 20878

**State Registrar**

31. Date filed (Month, Day, Year): MAR 13 2001
32. Registrar's Signature: Bruce B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 09458

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| KATHERINE | RUTH | TAYLOR | MARCH 11, 2001 | 10:43 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| PRINCE GEORGES GENERAL HOSPITAL | CHEVERLY | PRINCE GEORGES |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 246-52-1611 | 1☐M 2☒F | 61 Yrs. | | | AUG. 31, 1939 | NORTH CAROLINA |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | PRINCE GEORGES | SEAT PLEASANT | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 411 CEDARLEAF AVE. | 20743 | UNITED STATES |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify AFRO-AMERICAN |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12TH | 4 YEARS | SOCIAL WORKER | P.G. COUNTY STATE GOVERNMENT |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| RUFUS TAYLOR | ILLINOIS EDGE TAYLOR |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| HENRY E. TAYLOR / HUSBAND | 411 CEDARLEAF AVE., SEAT PLEASANT, MARYLAND 20743 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | FT. LINCOLN CEM. | MARCH 16, 2001 | BRENTWOOD, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Edward M. Dudley | DUDLEY FUNERAL HOME 3200 RHODE ISLAND AVE., MT. RAINIER, MD 20712 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Left Ventricular failure | 2 hrs |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. Cardiomyopathy | 10 yrs. |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension
Diabetes mellitus

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☒No 3☐Probably 4☐Unknown | 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ K Leach | D27521 | 3/12/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
KADIE LEACH M.D. 9500 ANNAPOLIS Rd A1 LANHAM, Md 20706

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 14 2001 | B. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036 GF

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

KATHERINE TAYLOR

12

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item #7 per WCCHD G794 4/13/01 EW

# Certificate of Death

2001 09459
Reg. No.

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| Lisa | Marie | VanStory-Bitner | March | 8 | 2001 | 1709 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| PENINSULA REGIONAL MEDICAL CENTER | SALISBURY | WICOMICO |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 240-08-7409 | 1☐ M 2☒ F | 44 ~~43~~ Yrs. | | | | | February 5, 1957 | Fayetteville, NC |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Wicomico | Salisbury | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 210 West Vine Street | 21801 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) | 14. Rece - American Indien, Bleck, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☐ No If Yes, Give Yeer or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 1+ | Homemaker | Domestic |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Meiden Surname) |
|---|---|
| William A. VanStory, III | Sonja --- Protenic |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Steve Bitner-Husband | 210 West Vine Street, Salisbury, MD 21801 |

| 20a. Method of Disposition | 20b. Piece of Disposition (Name of cemetery, crematory or other piece) | Dete | 20c. Location - City or Town, Stata |
|---|---|---|---|
| 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | | | |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Keith R. Downey CFSP | Holloway Funeral Home, Professional Association 501 Snow Hill Road, Salisbury, MD 21804 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heert failure. List *only one* cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Ventricular Tachycardia — 30 minutes

Due to (or as a consequence of):
b. Ischemic Heart Disease

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

Due to (or as e consequence of):
c.

Due to (or as e consequence of):
d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnency | 23d. Dete of delivery Month Day Year |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Liva birth 2☐ Fetal deeth 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hodgkin Disease

| 23e. Did tobecco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown | 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medicat examiner? | 26. Place of Deeth (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Menner of Death | 28a. Date of Injury (Month, Dey Year) | 28b. Time of Injury | 28c. Injury et Work? | 26d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) end menner as stated.
2☐ **Medical Examinar:** On the besis of examinetion and/or investigation, in my opinion, death occurred et the time, date end piece, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ M.D. | 030690 | March 8, 2001 |

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)
James E. MARTIN M.D. 145 E. Carroll St. Salisbury MD

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 13 2001 | ▶ Donna B Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To be Completed by Funeral Director**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Lisa VanStory-Bitner 240-08-7409 44 3/8/01 1709

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

ADMEND ITEM: #10E PER INFORMANT G794 4-2-01 MR

# Certificate of Death

Reg. No. 2001 09460

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Elizabeth Wentworth Morgan Vierling

2. Date of Death Month Dey Year: March 11, 2001

3. Time of Death: 4:42 pm

4a. Facility Name (If not institution, give street and number): Washington Adventist Hospital

4b. City, Town, or Location of Death: Takoma Park

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 579-10-5915

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 98 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Mar 2, 1903

9. Birthplace (State or Foreign Country): Massachusetts

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 8717 BRADFORD ROAD ~~8718 Bradford Road~~

10f. Zip Code: 20901

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specity Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indian, Black, Whita, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary of Publications

16b. Kind of Business/Industry: American Council on Education

17. Father's Name (First, Middle, Last): Leslie Wentworth Morgan

18. Mother's Neme (First, Middle, Maiden Surneme): Ruth May Seaton

19a. Informant's Neme/Relationship (Type, Print): Barbara Wentworth Bennett (daughter)

19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code): 8717 Bradford Road, Silver Spring, MD 20901

20e. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel from Stete 4☐ Donation 5☐ Other (Specify)

20b. Piece of Disposition (Name of cemetery, cremetory or other piece): Metropolitan Crematory

Dete: Mar 12 2001

20c. Location - City or Town, Stete: Alexandria, VA

21. Signeture of Funerel Service Licensee: Robert D. [illegible]

22. Name end Address of Feciliity: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

**Physician /Medical Examiner**

23a. Pert I. Enter the disease, or complications thet ceused the deeth. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart feilure. List only one ceuse on eech line.

Approximate Interval Between Onset and Deeth

Immediete Ceuse (Finel diseese or condition resulting in deeth): a. CONGESTIVE HEART FAILURE

Dua to (or es a consequence of): b. BREAST CANCER

Sequentially list conditions, if any, leading to immediete ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Last:

Due to (or as a consequence of): c.

Due to (or es a consequence of): d.

Pert II. **Other significant conditions** contributing to deeth but not resulting in the underlying ceuse given in Pert I.

23b. Did tobecco use contributa to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24e. Wes an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings availebie prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☑ Yes 2☐ No

26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☑ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and place, and dua to the cause(s) and menner steted.

29b. Signature and title of certifier: [signature]

29c. License number: D 48083

29d. Date signed (Month, Day, Year): MARCH 11, 2001

30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print): EMERGENCY DEPT. DR. IRVING WESTNEY, WASHINGTON ADVENTIST HOSPITAL.

**State Registrar**

31. Date filed (Month, Day, Year): MAR 14 2001

32. Registrer's Signeture: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Amend #23aPT1&2,3/16/2001,BMW,Montg.Co. *Certificate of Death* Reg. No. 2001 09461

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Jon E. Van Cleve | March 14,2001 | 12:12 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| MONTGOMERY GENERAL HOSPITAL | OLNEY | MONTGOMERY |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216 48 8357 | 1☒M 2☐F | 55 Yrs. | | | SEPT.24,1945 | SOUTH DAKOTA |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD. | MONTGOMERY | OLNEY | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 18413 QUEEN ELIZABETH DRIVE | 20832 | UNITED STATES |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementery/Secondery (0-12) | College (1-4or 5+) | | |
| 12 | 0 | OWNER - OPERATOR | HEATING AND AIR COMPANY |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Meiden Sumeme) |
|---|---|
| Maurice Van Cleve | Julia Morrisey |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Diane L. Van Cleve, Wife | 18413 Queen Elizabeth Drive, Olney, Md. 20832 |

| 20a. Method of Disposition | 20b. Piece of Disposition (Name of cemetery, cremetory or other piece) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Gate Of Heaven Cemetery | 3/17/01 | Silver Spring, Md. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Muriel H. Barber | MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882 |

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Baltimore, Maryland 21215-0036**

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the diseese or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heert failure. List only one cause on eech line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Finai diseese or condition resulting in death) | a. Chronic Renal Failure | 2 years |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last | b. Cerebrovascular Accidents | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as e consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

~~Cerebrovascular Accidents~~

Type II Diabetes

23b. **Did tobacco use contribute to the cause of death?** 1☐Yes 2☑No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were eutopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☑No | 1☐Yes 2☑No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☑No | Hospitel: 1☐Inpatient 2☑ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑Netural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined | | M | 1☐Yes 2☐No | |
| | 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) | | | 28f. Location (Street end Number or Rural Route Number, City or Town, State) |

29e. Certifier (Check only one)
1☑**Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) and mennar as stated.
2☐**Medical Examiner**: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete and place, and due to the cause(s) and menner steted.

| 29b. Signature and title of certifier | 29c. License number | 29d. Dete signed (Month, Dey, Year) |
|---|---|---|
| ▶ | D18726 | March 14, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ARTHUR SCHWENGOLD, MD 18101 Prince Philip Drive, Olney, MD 20832

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Division of Vital Records, P.O. Box 68760,**

**State Registrar**

| 31. Dete filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 16 2001 | ▶ G. Sparks |

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09462

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Ruth M. Woolley

2. Date of Death: Month March, Day 14, Year 2001

3. Time of Death: 7:15 AM

4a. Facility Name (If not institution, give street and number): Shady Grove Adventist Nursing Center

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 577-46-4708

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): July 11, 1915

9. Birthplace (State or Foreign Country): Michigan

Usuet Residence of Decedent

10a. Stete: Maryland

10b. County: Montgomery

10c. City, Town or Location: Kensington

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 10217 Summit Avenue

10f. Zip Code: 20895

10g. Citizen of What Country?: United States

11. Merital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- It Yes, specity Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - Americen Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12); College (1-4or 5+): 3

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Mathematician

16b. Kind ot Business/Industry: Federal Government

17. Father's Neme (First, Middle, Last): Edwin Mowry

18. Mother's Neme (First, Middle, Maiden Surneme): Cora Hadley

19a. Informant's Neme/Relationship (Type, Print): John W. Woolley/Son

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 1033 South Hoga Road, Sterling, Virginia 20164

20a. Method ot Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Plece of Disposition (Neme of cemetery, cremetory or other place): Parklawn Memorial Park

Dete: Mar 20 2001

20c. Location - City or Town, Stete: Rockville, Maryland

21. Signeture of Funeral Service Licensee: M00689

22. Neme and Address ot Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave. Bethesda, Maryland 20814-3501

**Physician /Medical Examiner**

23a. Part I. Enter the diseses, or complicetions thet ceused the deeth. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart teilure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediete Cause (Final disease or condition resulting in deeth)

a. Aspiration Pneumonia — 1 Week

Due to (or es e consequence ot):

Sequentielly list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Last

b. Congestive Heart Failure — 1 Week

Due to (or es e consequence ot):

c. Cerebrovascular Accident — Years

Due to (or as e consequence of):

d.

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer)

28b. Time ot Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece ot Injury - At home, term, street, fectory, offica building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best ot my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of exemination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and menner steted.

29b. Signeture and Title of Certifier

29c. License number: D35792

29d. Date signed (Month, Day, Year): March 15, 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Swaroop G. Rao, M.D. 50 West Edmonston Drive, #504, Rockville, Maryland 20852

**State Registrar**

31. Dete filed (Month, Day, Year): MAR 16 2001

32. Registrer's Signeture: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 09463

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Data of Death Month Day Yaar | 3. Time of Death |
|---|---|---|
| WINIFRED B. WINSTON | MARCH 9, 2001 | 8:34 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Montgomery General Hospital | Olney | MONTGOMERY |

**Funeral Director**

| 5. Social Security Number | 8. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year Months / Days | If Under 24 Hrs. Hours / Min. | 8. Data of Birth (Month, Day, Yaar) | 9. Birthplace (State or Foraign Country) |
|---|---|---|---|---|---|---|
| 051-26-6340 | 1☐M 2☒F | 70 Yrs. | | | Jan.13,1931 | New York |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Montgomery | Silver Spring | 1☐Yas 2☒No |

| 10e. Street and Number | 10f. Zip Coda | 10g. Citizen of What Country? |
|---|---|---|
| 3974 Bel Pre Road, #7 | 20906 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) | 14. Race - Amarican Indian, Black, Whita, atc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yas 2☒No Specify: | Specify: Black |

| t5. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired) | 16b. Kind of Businass/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12th | | Cashier | Howard University |

| 17. Father's Nama (First, Middle, Last) | 18. Mothar's Nama (First, Middla, Maidan Surname) |
|---|---|
| Charles W. Robertson | Emma Murphy |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) |
|---|---|
| David Sidbury (Son) | 9501 Ardwick-Ardmore Rd., Springdale, MD 20774 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or othar place) | Data | 20c. Location - City or Town, Stata |
|---|---|---|---|
| ☒Burial 2☐Cremation 3☐Removal from Stata 4☐Donation 5☐Other (Specify) | Arlington Nat'l Cem | 3/22/01 | Ft. Myer, VA |

21. Signature of Funeral Service Licensee: George R. Snowden

22. Nama and Addrass of Facility: SNOWDEN FUNERAL HOME, P.A. 246 N. Wash. St., Rockville, MD 20850

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onsat and Death |
|---|---|---|
| Immediata Cause (Final disease or condition resulting in death) | MYOCARDIAL INFARCTION | 4 DAYS |
| a. | Dua to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — b. | Due to (or as a consequence of): | |
| c. | Due to (or as a consequence of): | |
| d. | | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yas 2☐No 9☐Unknown | 23c. If yes, outcoma of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Othar (specify) 9☐Unknown | 23d. Data of dalivary Month Day Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause givan in Part I.

END STAGE RENAL DISEASE

| 23a. Did tobacco usa contributa to the cause of death? | 24a. Was an autopsy performed? | 24b. Wara autopsy findings available prior to completion of causa of daath? |
|---|---|---|
| 1☐Yas 2☐No 3☐Probably 4☒Unknown | 1☐Yas 2☒No | 1☐Yas 2☐No |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

| 25. Was case referred to medical examiner? | 28. Placa of Death (Check only one) | |
|---|---|---|
| 1☐Yas 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Othar: 4☐Nursing Homa 5☐Rasidance 6☐Othar (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| t☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be datarmined | | M | 1☐Yas 2☐No | |

| 26e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) |
|---|---|
| | |

29a. Certifier (Check only one)
t☒ **Certifying Physician:** To the best of my knowledge, death occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated.
2☐ **Medical Examiner:** On tha basis of examination and/or invastigation, in my opinion, death occurred at tha tima, date and place, and due to tha cause(s) and manner stated.

| 29b. Signature and title of cartifier | 29c. Licensa number | 29d. Date signad (Month, Day, Year) |
|---|---|---|
| MD | D21340 | MARCH 10, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAYMOND BASS 3941 FERRARA DRIVE WHEATON, MD 20906

**State Registrar**

| 31. Data filed (Month, Day, Year) | 32. Registrar's Signatura |
|---|---|
| MAR 15 2001 | Donna B. Sparks |

DHMH 17 Rav 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09464

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ROBERT EDMOND WINDSOR
2. Date of Death (Month, Day, Year): MARCH 10, 2001
3. Time of Death: 5:30 PM
4a. Facility Name (If not institution, give street and number): WASHINGTON ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: TAKOMA PARK
4c. County of Death: MONTGOMERY

**Funeral Director**

5. Social Security Number: 215 72 8584
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 41 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MARCH 14, 1959
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD.
10b. County: FREDERICK
10c. City, Town or Location: POINT OF ROCKS
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 3724 CLAY ST.
10f. Zip Code: 21777
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DAIRY MANAGER
16b. Kind of Business/Industry: FOOD STORE

17. Father's Name (First, Middle, Last): ROBERT E. WINDSOR, SR.
18. Mother's Name (First, Middle, Maiden Surname): ELVA FRAZIER

19a. Informant's Name/Relationship (Type, Print): KATHLEEN A. WINDSOR, WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. BOX 263, POINT OF ROCKS, MD. 21777

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GERMANTOWN BAPTIST CEM. | Date: 3/15/01
20c. Location - City or Town, State: GERMANTOWN, MD.

21. Signature of Funeral Service Licensee: ▶ Muriel H. Barber
22. Name and Address of Facility: MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882

**Physician /Medical Examiner**

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. STAPHYLOCOCCAL SEPSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Margaret S. Choa
29c. License number: D17197
29d. Date signed (Month, Day, Year): 03/11/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARGARET S. CHOA, M.D., 7610 CARROLL AVE. #360, TAKOMA PARK, MD. 20912

**State Registrar**

31. Date filed (Month, Day, Year): MAR 13 2001
32. Registrar's Signature: ▶ D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM #5 per fh G794 041301 SS

# Certificate of Death

Reg. No: 2001 09465

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: LUCY WILLIAMS

2. Date of Death Month: MARCH Day: 7 Year: 2001

3. Time of Death: 02:10

4a. Facility Name *(If not institution, give street and number)*: HARBOR HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

**Funeral Director**

5. Social Security Number: ~~007-10-4095~~ 231-40-6721

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 102 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Feb. 14, 1899

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: MD

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 7070 Timberfield Place

10f. Zip Code: 21126

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Berkley Sims

18. Mother's Name *(First, Middle, Maiden Surname)*: Fannie Rice

19a. Informant's Name/Relationship *(Type, Print)*: Sarah Holmes - Granddaughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7070 Timberfield Place Baltimore, MD 21126

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: High Bridge Bapt Ch Cem

Date: 3/11/01

20c. Location - City or Town, State: Rice, Virginia

21. Signature of Funeral Service Licensee: Karen L. Woodall

22. Name and Address of Facility: Metropolitan Funeral Service, Inc. 5517 Vine St Alexandria, VA 22310

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Acute pneumonia — 7 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

hypertension

coronary artery disease

congestive heart failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Peter Craig MD

29c. License number: P 14427

29d. Date signed *(Month, Day, Year)*: MARCH, 7, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PETER CRAIG 3001 SOUTH HANOVER STREET, BALTIMORE, MD 21225

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 12 2001

32. Registrar's Signature: Bruce G. Sooks

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as soon as possible.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit case.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09466

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Bertha Rebecca Whittington
2. Date of Death (Month, Day, Year): March 11, 2001
3. Time of Death: 445pm
4e. Facility Name (If not institution, give street and number): Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 579-16-1558
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 79 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 23, 1921
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Derwood
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 15404 Indianola Dr.
10f. Zip Code: 20855
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): William D. Cosgrave
18. Mother's Name (First, Middle, Maiden Surname): Frances C. Nichols

19e. Informant's Name/Relationship (Type, Print): Nancy McFadden /Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15404 Indianola Dr., Derwood, MD 20855

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parklawn Memorial Park
Date: Mar 14 2001
20c. Location - City or Town, State: Rockville, MD

21. Signature of Funeral Service Licensee: ▶ Beverly L Hedrick
22. Name and Address of Facility: Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, MD

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonitis
Due to (or as a consequence of):
b. Sepsis
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Diabetes mellitis
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Congestive heart failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature]
29c. License number: D 23170
29d. Date signed (Month, Day, Year): MARCH 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Alpana Goswami 10901 Connecticut Ave Kensington, MD 20895

**State Registrar**

31. Date filed (Month, Day, Year): MAR 13 2001
32. Registrar's Signature: ▶ [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 09467

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Elizabeth B. Whitaker
2. Date of Death Month Day Year: Mar. 12, 2001
3. Time of Death: 1:25 AM.
4a. Facility Name *(If not institution, give street and number)*: 4613 Harrison Street
4b. City, Town, or Location of Death: Chevy Chase
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 217-34-8978
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 69 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Oct. 13, 1931
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Chevy Chase
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4613 Harrison Street
10f. Zip Code: 20815
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12); College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Housewife

17. Father's Name *(First, Middle, Last)*: Robert Emmet Bradley
18. Mother's Name *(First, Middle, Maiden Surname)*: Adelaide Fesenmeir

19a. Informant's Name/Relationship *(Type, Print)*: John C. Whitaker - Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4613 Harrison St., Chevy Chase, Md. 20815

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: St. Marks Episc. Cemetery
Date: 3/16/01
20c. Location - City or Town, State: Perryville, Md.

21. Signature of Funeral Service Licensee: ▶ W. Clyde Mears
22. Name and Address of Facility: Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. NW., Washington, D.C. 20016

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pancreatic Carcinoma — 1 Month

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Robert H Blee MD
29c. License number: D23556
29d. Date signed *(Month, Day, Year)*: March 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert H. Blee, MD. 5530 Wisconsin Ave. #1400, Chevy Chase, Md. 20815-4301

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 13 2001
32. Registrar's Signature: ▶ Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

15

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 09468

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Srisoma Welivitigoda

2. Data of Death Month Day Year: March 13, 2001

3. Time of Death: 6:50pm

4a Facility Name *(If not institution, give street and number)*: SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

**Funeral Director**

5. Social Security Number: 212-47-6021

8. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 95 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 21, 1905

9. Birthplace *(State or Foreign Country)*: Sri Lanka

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Montogmery Village

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 20804 Aspenwood Lane

10f. Zip Code: 20886

10g. Citizen of What Country?: Sri Lanka

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Ricen, atc.) 1☐ Yes 2☒ No *Specify:*

14. Rece - American Indian, Black, Whita, etc. *Specify:* Asian

15. Decedent's Education *(Specify only highast grada completed)*: Elemantary/Secondary (0-12): ; Collega (1-4or 5+): 5+

16a. Decedant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT use retired)*: Headmaster

16b. Kind of Businass/Industry: Education

17. Fathar's Name *(First, Middla, Last)*: Porolis Weliwitigoda

18. Mothar's Nama *(First, Middle, Maidan Sumama)*: Pintho UNKNOWN

19a. Informant's Name/Ralationship *(Type, Print)*: Sepala Weliwitigoda (Son)

19b. Mailing Address *(Street and Number or Rurel Routa Number, City or Town, Stata, Zip Code)*: 20804 Aspenwood Lane, Montgomery Village, MD 20886

20a. Method of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Placa of Disposition *(Nama of cematary, cramatory or othar place)*: Metropolitan Crematory

Data: 3/15/01

20c. Location - City or Town, Stata: Alexandria, Virginia

21. Signature of Funaral Sarvica Licensee: Robert A. DeVol

22. Nama and Address of Facility: DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877

**Physician /Medical Examiner**

23a. Part I. Enter the diseasa, or complications thet caused the death. Do not antar tha mode of dying, such as cardiac or raspiratory arrast, shock, or heart failura. List only ona causa on aach lina.

| | | Approximata Intarval Batween Onset and Death |
|---|---|---|
| Immediata Causa (Final diseasa or condition resulting in death) a. | Congestive Heart Failure | 30 Days |
| Dua to (or as a consequance of): | | |
| Sequentially list conditions, if any, leading to immediata cause. Entar Underlying Cause (Disaasa or injury that initiated events resulting in death) Last b. | Acute Myocardial Infarction | 30 Days |
| Dua to (or as a consequence of): | | |
| c. | Acute Respiratory Failure | 30 Days |
| Dua to (or as e consequanca of): | | |
| d. | Renal Failure | |

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.: Anemia, Pneumonia

23b. Did tobacco uas contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to completion of cause of death? 1☐ Yas 2☒ No

25. Was casa rafarrad to medical examinar? 1☐ Yas 2☒ No

26. Placa of Daath *(Check only ona)*: Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA; Othar: 4☐ Nursing Homa 5☐ Rasidence 6☐ Othar *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Panding investigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Place of Injury - At homa, farm, street, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To tha best of my knowledge, death occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner**: On the basis of axamination and/or investigation, in my opinion, daath occurred at tha tima, data and piaca, and dua to tha cause(s) and mannar stated.

29b. Signature and titla of certifier: Vinu Gupta

29c. Licensa number: D41162MD

29d. Data signed *(Month, Day, Year)*: March 14 2001

30. Nama and address of person who complated causa of death (Item 23a) (Type, Print): V Gupta MD 19529 Doctori Drive Gtown MD 20874.

**State Registrar**

31. Data filed *(Month, Day, Year)*: MAR 16 2001

32. Registrar's Signatura: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit pass.

Medical Certification: To Be Completed by Physician/Medical Examiner

4

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09469

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Dey Year | 3. Time of Death |
|---|---|---|
| Hope A. Weisz | March 7, 2001 | 8:20 PM. |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Suburban Hospital | Bethesda | Montgomery |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Yeer Months | Days | If Under 24 Hrs. Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 115-14-1404 | 1☐M 2☒F | 77 Yrs. | | | | | May 23, 1923 | New York |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Montgomery | Rockville | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 11601 Farmland Drive | 20852 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) | 14. Race - American Indien, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 4 | Media Specialist | Montgomery County Public Schools |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surneme) |
|---|---|
| Ray Anable | Harriet Russell |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) |
|---|---|
| Charles P. Weisz/Husband | 11601 Farmland Drive, Rockville, Maryland 20852 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, cremetory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Montgomery Crematorium, Inc. | March 9, 2001 | Bethesda, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Neme end Address of Facility |
|---|---|
| ▶ Ray Fuh M00198 | Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 |

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complicelions that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximete Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Multi System Organ Failure | 48 Hours |
| Due to (or as a consequence of): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated eventa resulting in death) Last | b. Diabetes | 10 Years |
| Due to (or as a consequence of): | | |
| | c. Pneumonia | 48 Hours |
| Due to (or es a consequence of): | | |
| | d. Atrial Fibrillation | 1½ Months |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Hypertension, Asthma, Hypercholesterolemia

23b. Did tobacco use contribute to the cause of death? 1☐Yee 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings aveilable prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medicel examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Dey Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street end Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

WEISZ, HOPE 3/7/2001 2045

20

29a. Certifier (Check only one) 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ | D0053269 | March 8, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Al Nick 11125 Rockville Pike #209, Rockville, Maryland 20852

**State Registrar**

| 31. Dete filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 12 2001 | ▶ G. Sparks |

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09470

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Olga Wrobleski Webb
2. Date of Death Month Day Year: March 12, 2001
3. Time of Death: 2:30pm
4a. Facility Name *(If not institution, give street and number)*: 10500 Rockville Pike #1421
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 087-24-8059
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 69 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Aug 10, 1931
9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 10500 Rockville Pike #1421
10f. Zip Code: 20852
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12) / College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Architect
16b. Kind of Business/Industry: Real Estate

17. Father's Name *(First, Middle, Last)*: Joseph Wrobleski
18. Mother's Name *(First, Middle, Meiden Surname)*: Olga Bednarchuk

19a. Informent's Neme/Reletionship *(Type, Print)*: Frank Wroblewski /Brother
19b. Meiling Address *(Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 1662 Coughlin St., Laramie, WY 82072

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Piece of Disposition *(Name of cemetery, cremetory or other place)*: Chesapeake Crematory
Dete: Mar 14 2001
20c. Location - City or Town, State: Beltsville, MD

21. Signeture of Funeral Service Licensee: Robert Lohmann
22. Name and Address of Facility: Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, MD

**Physician /Medical Examiner**

23e. Part1. Enter the disease, or complicetions that ceused the death. Do not enter the mode ot dying, such as cerdiac or respiretory errest, shock, or heart tailure. List only one cause on each line.

Approximate Intervel Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. advanced liver cirrhosis — 20 yrs
Due to (or es e consequence of):
b. alcoholism — 40 yrs.

Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other signiflcent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings aveilable prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medicel examiner? 1☐ Yes 2☒ No
26. Place of Deeth *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner ot Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined
28a. Date ot Injury *(Month, Day Year)*
28b. Time ot Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, tarm, street, factory, office building, etc. *(Specify)*
28t. Location *(Street and Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete and piece, end due to the cause(s) end mannar as stated. 2☐ **Medical Examiner:** On the basis of examination and/or Investigetion, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner steted.

29b. Signature and titie of certifier: Julie L. Farley Pina MD
29c. License number: D0056015
29d. Date signed *(Month, Dey, Year)*: 3/13/01

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Julie Farley-Pina M.D., 11125 Rockville Pike #103, Rockville, MD 20832

**State Registrar**

31. Date filed *(Month, Dey, Year)*: MAR 16 2001
32. Registrar's Signature: Bernice B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09471

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): FREDERICK LEE WATERS
2. Date of Death (Month, Day, Year): MARCH 08, 2001
3. Time of Death: 8:47 PM

4a. Facility Name (If not institution, give street and number): WASHINGTON ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: TAKOMA PARK
4c. County of Death: MONTGOMERY COUNTY

**Funeral Director**

5. Social Security Number: 579-70-3564
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 47 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MARCH 20, 1953
9. Birthplace (State or Foreign Country): WASHINGTON, DC

Usual Residence of Decedent

10a. State:
10b. County: N/A
10c. City, Town or Location: WASHINGTON , D.C.
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1512 VAN BUREN STREET N.W.
10f. Zip Code: 20012
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: AFRO-AMERICAN

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11TH; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): FISHERMAN
16b. Kind of Business/Industry: PRIVATE

17. Father's Name (First, Middle, Last): WILLIAM FREDERICK WATERS, JR.
18. Mother's Name (First, Middle, Maiden Surname): JEANETTE C. MACK

19a. Informant's Name/Relationship (Type, Print): JEANETTE C. MACK / MOTHER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6449 KANSAS LANE, TAKOMA PARK, MARYLAND 20912

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): HARMONY MEM. PARK CEM.
Date: MARCH 16, 2001
20c. Location - City or Town, State: LANDOVER, MD

21. Signature of Funeral Service Licensee: Edward M. Dudley
22. Name and Address of Facility: DUDLEY FUNERAL HOME 3200 RHODE ISLAND AVE., MT. RAINIER, MD 20712

**Physician /Medical Examiner**

23a. Part1. Enter the diseasa, or complications that caused the daath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Multisystem failure.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. CVA, Renal-Hepatic Cardiac Respiratory failure,

Due to (or as a consequence of):
c.

Due to (or as a consequanca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yas 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Suresh Khetan
29c. License number: D55403
29d. Date signed (Month, Day, Year): 3/9/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SURESH KHETAN, M.D.; 7610 CARROLL AVE., TAKOMA PARK, MARYLAND 20912

**State Registrar**

31. Date filed (Month, Day, Year): MAR 14 2001
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

01-1353-031
mnmr
Robert W. Walker

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 09472

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Robert W. Walker | March 09, 2001 | 1640 pM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 13103 Dairymaid Drive | Germantown | Montgomery |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-60-9763 | 1☒M 2☐F | 49 Yrs. | | | Nov. 30, 1951 | Washington, DC |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Montgomery | Germantown | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 13103 Dairymaid Drive | 20874 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Supervisor | Quarry |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Billy J. Walker | Mary Joan Daniels |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Debora K. Walker/Wife | 13103 Dairymaid Drive, Germantown, Maryland 20874 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Montgomery Crematorium, Inc. | March 12, 2001 | Bethesda, Maryland |

| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility |
|---|---|---|
| ▶ Robert A. Pumphrey | M00198 | Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Ave., Rockville, MD 20850-2805 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC TAMPONADE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. RUPTURED MYOCARDIAL INFARCTION

Due to (or as a consequence of):

c. CORONARY ARTERY THROMBOSIS

Due to (or as a consequence of):

d. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown | 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | 23d. Date of delivery Month Day Year |
|---|---|---|
| | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☒Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☒Yes 2☐No | 1☒Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☒Yes 2☐No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) at scene |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ M.D. | O.C.M.E. | March 10, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARY C. RIPPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 12 2001 | ▶ B. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

By permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

12

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

## Certificate of Death

Reg. No. 2001 09473

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Jean Elizabeth Young | March 06, 2001 | 10:48a.m. |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Frederick Memorial Hospital | Frederick | Frederick |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-28-8310 | 1☐M 2☒F | 76 Yrs. | | | Aug. 30, 1924 | MD. |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| W. VA. | Berlley | Harpers Ferry | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| Rt. 3 Box 520 | 25425 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | nurses aide | hospital |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Samuel Columbus Grams | Minnie Mae Butts |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Maryland V. Horman (Daughter) | 103 S. Main St., Woodsboro, MD. 21798 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Data | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Locust Valley Ceemetery 3/9 | | Middletown, MD. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Donald B. Thompson | Donald B. Thompson Funeral Home 31 E. Main St., Middletown, MD. 21769 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Subdural hematoma | 1-3 wks |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. Aspiration Pneumonia | 2 days |
| | Due to (or as a consequence of): c. Intestinal Obstruction | 2 days |
| | Due to (or as a consequence of): d. Dementia | 20 yrs |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☒No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Swami Nathan MD | D18414 | 3-6-01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SWAMI NATHAN, MD 158 T-J-2 #207 FREDERICK, Md. 21702

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 13 2001 | ▶ Geneva B Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09474

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Joseph J. Zaccagnino

2. Date of Death (Month, Day, Year): March 8, 2001

3. Time of Death: 9:50pm

4a. Facility Name (If not institution, give street and number): Montgomery Village Care & Rehab.

4b. City, Town, or Location of Death: Montgomery Village

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 062-14-3752

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 93 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Mar. 19, 1907

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Md.

10b. County: Montgomery

10c. City, Town or Location: Germantown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 13120 Wonderland Way #103

10f. Zip Code: 20874

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Deputy U.S. Marshal

16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): Canio Zaccagnino

18. Mother's Name (First, Middle, Maiden Surname): Rose Marie Telesca

19a. Informent's Name/Relationship (Type, Print): Mary V. Zaccagnino (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13120 Wonderland Way #103 Germantown,Md. 20874

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Church Boyds Presbyterian

Date: Mar. 12, 2001

20c. Location - City or Town, State: Boyds, Maryland

21. Signature of Funeral Service Licensee: ▶ Curtis E. Day

22. Name and Address of Facility: DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, Md. 20877

**Physician /Medical Examiner**

23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avents resulting in death) Last

b. Congestive Heart Failure

Due to (or as a consequence of):

c. Coronary Artery Disease

Due to (or as a consequence of):

d. Acute Respiratory Failure

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yas 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yas 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as stated. 2☐ Medical Examiner: On the basis of examination and/or Investigation, In my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Vinu Ganti

29c. License number: D41162

29d. Data signed (Month, Day, Year): March 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Vinu Ganti M.D. 19529 Doctors Dr. Germantown, Md. 20874

**State Registrar**

31. Date filed (Month, Day, Year): MAR 12 2001

32. Registrar's Signature: ▶ Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

## Certificate of Death

Reg. No. 2001 09475

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Helen Elizabeth Aldred

2. Date of Death: Month March, Day 26, Year 2001

3. Time of Death: 6:35A M

4a. Facility Name (If not institution, give street and number): Ridgeway Manor

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 705-05-7457

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 99 Yrs.

If Under 1 Year: Months ____ Days ____

If Under 24 Hrs.: Hours ____ Min. ____

8. Date of Birth (Month, Day, Year): Dec. 24, 1901

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 5743 Edmondson Avenue

10f. Zip Code: 21228

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

16b. Kind of Business/Industry: Railroad

17. Father's Name (First, Middle, Last): Ernest L. Cook

18. Mother's Name (First, Middle, Maiden Surname): Amelia Jane Berryman

19a. Informant's Name/Relationship (Type, Print): Alan J. Knauer - nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 21 Fernwood Court, Medford, New Jersey 08055

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Woodlawn Cemetery

Date: 3/29/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Ann G. Zink

22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 21229

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Inanition — few days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Congestive Heart Failure — few weeks

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) ____ 9☐ Unknown

23d. Date of delivery: Month ____ Day ____ Year ____

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia, osteo arthritis, macular degeneration.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Geetha Raja MD

29c. License number: D27541

29d. Date signed (Month, Day, Year): March 26, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): GEETHA RAJA, 4367 HOLLINS FERRY RD, BALTIMORE, MD-21227

**State Registrar**

31. Date filed (Month, Day, Year): MAR 2 8 2001

32. Registrar's Signature: ▶ Jeanne B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Amend Item#20b perFHG794 4/2/2001 EW

## Certificate of Death

Reg. No. 2001 09476

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| WILLIAM | ASHLEY | | MARCH 23 2001 | 8:02AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| VILLA ST. MICHAEL NURSING HOME | BALTIMORE | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 237-74-8705 | 1☒ M 2☐ F | 52 Yrs. | | | MAY 13, 1948 | NORTH CAROLINA |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | N/A | BALTIMORE CITY | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3503 HOLMES AVENUE | 21217 | USA. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 9TH GRADE | | FORKLIFT OPERATOR | FACTORY |

| 17. Father's Name (First, Middle, Last) | | 18. Mother's Name (First, Middle, Maiden Surname) | |
|---|---|---|---|
| GASTON | ASHLEY | MARIE | ROBERSON |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| EMMALINE STEWART (SISTER) | 3503 HOLMES AVENUE, BALTIMORE, MD. 21217 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | METRO CREMATORY | 3-27-01 | BALTIMORE, MARYLAND |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Richard N. Brown | JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTO, MD. 21217 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Human Immunodeficiency Virus Syndrome

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

1) End Stage Renal disease. Hepatitis B, C
2) Hypertrophic Cardiomyopathies;

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how Injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)

1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| D Sealy | D17537 | 3-27-01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DARSHAN S. SALUJA MD 1600 W. MOUNT Royal Ave, Balto 21217

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 28 2001 | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09477

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): IRENE BRESSLER
2. Date of Death: Month March Day 22 Year 2001
3. Time of Death: 1056
4a. Facility Name (If not institution, give street and number): North West Hospital Center
4b. City, Town, or Location of Death: RANDALLSTOWN
4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 214-16-6355
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Yaar: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUG.4,1910
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 6626 CHIPPEWA DRIVE
10f. Zip Code: 21209
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ASSISTANT
16b. Kind of Business/Industry: ACCOUNTING

17. Father's Name (First, Middle, Last): MAX SCHERR
18. Mother's Name (First, Middle, Maiden Surneme): MOLLIE LUDWIG

19a. Informant's Name/Relationship (Type, Print): VICTOR BRESSLER / HUSBAND
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 6626 CHIPPEWA DRIVE - BALTIMORE, MD 21209

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othar (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): BETH EL MEMORIAL PARK
Date: 3/25/01
20c. Location - City or Town, Stata: RANDALLSTOWN, MD

21. Signatura of Funeral Service Licensee: ▶ Robert Zimmerman
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disaase or condition resulting in death)
a. Pneumonia
Due to (or as a consequence of):
b. Complete Heart Block / Asystole
Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Ischemic Cardiomyopathy
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yas 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at tha tima, date and placa, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Joseph Sachmo MD
29c. Licensa number: D18538
29d. Date signed (Month, Day, Year): March 23.2001
30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): Joseph SaChmo MD (1838 Greene Tree, Baltimore, Md, 21208

**State Registrar**

31. Date filed (Month, Day, Year): MAR 2 8 2001
32. Registrar's Signature: ▶ Brenda G Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09478

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ANTHONY EDWARD CAROLINA
2. Date of Death (Month, Day, Year): MARCH 22, 2001
3. Time of Death: 11:49AM
4a. Facility Name (If not institution, give street and number): BON SECOURS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 214-64-6614
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 45 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JULY 24, 1955
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 2731 RIGGS AVENUE
10f. Zip Code: 21216
10g. Citizen of What Country?: USA.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9TH GRADE; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): JOHN E. CARROLL
18. Mother's Name (First, Middle, Maiden Surname): RUTH FREEMAN

19a. Informant's Name/Relationship (Type, Print): TINA WATKINS (SISTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2731 RIGGS AVE., BALTIMORE, MD. 21216

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): METRO CREMATORY
Date: 3-28-01
20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTO, MD. 21217

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. AIDS
Due to (or as a consequence of):
b. Substance abuse

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [X] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D33026
29d. Date signed (Month, Day, Year): 3/27/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): [illegible] Baltimore md 21201

**State Registrar**

31. Date filed (Month, Day, Year): MAR 28 2001
32. Registrar's Signature: [signature]

ORIGINAL

DHMH 16 Rev 6/95

---

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit copy.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09479

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Joseph F. Campbell, Sr.

2. Date of Death Month: MARCH Day: 25 Year: 2001

3. Time of Death: 1557

4a. Facility Name *(If not institution, give street and number)*: ST AGNES HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 219-16-6902

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov. 16, 1923

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Arbutus

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1004 Beechfield Ave.

10f. Zip Code: 21229

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1943-1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Fireman

16b. Kind of Business/Industry: Saftey

17. Father's Name *(First, Middle, Last)*: John J. Campbell

18. Mother's Name *(First, Middle, Maiden Surname)*: Nora Fleck

19a. Informant's Name/Relationship *(Type, Print)*: Alma Campbell, Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1004 Beechfield Ave. Arbutus, MD. 21229

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Meadowridge Memorial Park Date: 3-29-01

20c. Location - City or Town, State: Elkridge, MD

21. Signature of Funeral Service Licensee: Rebecca Robertson

22. Name and Address of Facility: Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 21227

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | SEPSIS | 10 days |
| Due to (or as a consequence of): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. | ASPIRATION PNEUMONIA | 4 days |
| Due to (or as a consequence of): | | |
| c. | | |
| Due to (or as a consequence of): | | |
| d. | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Shirin Ahmad RESIDENT PHYSICIAN

29c. License number: P144138

29d. Date signed *(Month, Day, Year)*: MARCH 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SHIRIN AHMAD 900 CATON AVE BALTIMORE, MARYLAND 21229.

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 28 2001

32. Registrar's Signature: Jeanne G. Sparks

ORIGINAL

DHMH 16 Rev 6/95

---

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

NAME JOSEPH, F, CAMPBELL, SR.

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09480

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Della May Cannon
2. Date of Death (Month, Day, Year): March 26, 2001
3. Time of Death: 5:25PM
4a. Facility Name *(If not institution, give street and number)*: Joseph Ritchey Hospice
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 217-40-5171
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 90 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: March 8, 1911
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Halethorpe
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5554 Ashbourne Rd.
10f. Zip Code: 21227
10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Clifford Unglesbee
18. Mother's Name *(First, Middle, Maiden Surname)*: Minnie Warfield

19a. Informant's Name/Relationship *(Type, Print)*: Raymond L. Cannon, Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5554 Ashbourne Rd. Halethorpe, MD. 21227

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Loudon Park Cemetery
Date: 3-30-01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Rebecca Robertson
22. Name and Address of Facility: Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 21227

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiomyopathy — 2 yrs
Due to (or as a consequence of):
b. Coronary Artery Disease — 5 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* Inpt Hospice
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Tredell W Tolchart III MD
29c. License number: D33400
29d. Date signed *(Month, Day, Year)*: 03/26/2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Tredell W Tolchart III MD 500 Wunnerstty Pkwy Baltimore MD 21210

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 28 2001
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

5:25 pm 3-26-01 DeLLA CANNON

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND#20b PER F.H. G793 3-28-2001 JAB

# Certificate of Death

Reg. No. 2001 09481

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|
| RUTH | CAPLAN | MARCH 24, 2001 | 10:30 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| GENESIS ELDERCARE - RANDALLSTOWN | RANDALLSTOWN | BALTIMORE |

**Funeral Director**

| 5. Social Security Number | 8. Sex 1☐M 2☒F | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-09-9029 | | 82 Yrs. | | | JULY 20, 1918 | MD |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | BALTIMORE | BALTIMORE | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 6960 MARSUE DRIVE #T-2 | 21215 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Rece - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No | 1☐Yes 2☒No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 9 | | SALESWOMAN | RETAIL CLOTHING |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| MICHAEL DUGAN | MOLLIE SCHUSTER |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| MICHAEL CAPLAN / SON | 17709 GEORGIA AVENUE - OLNEY, MD 20833 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | ARLINGTON CHIZUK AMUNO | 3/~~27~~26/01 | BALTIMORE, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Robert Levinson | SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Urosepsis | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

End Stage Dementia

Atherosclerotic Coronary Artery Disease

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☒No |

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: ☒Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 26c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Shalini Tewari M.D. | D52671 | March 25, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shalini Tewari M.D. / 1838 Greene Tree Road / Suite 300 / Pikesville, MD 21208

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 28 2001 | Barbara D Sparks |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09482

AMEND ITEM 23a, 25 per phys G793 032901 SS

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: ISADORE B. COHEN

2. Date of Death (Month, Day, Year): March 15 2001

3. Time of Death: 17:15

4a. Facility Name *(If not institution, give street and number)*: Sinai Hospital of Baltimore

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 215-01-3759

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JUNE 2,1914

9. Birthplace *(State or Foreign Country)*: MD.

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 3203 PARKINGTON AVE.

10f. Zip Code: 21215

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify*: WHITE

15. Decedent's Education *(Specify only highest grada completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work dona during most of working life. DO NOT use retired)*: INVESTIGATOR

16b. Kind of Business/Industry: STATE'S ATTORNEY OFFICE

17. Father's Name *(First, Middle, Last)*: DANIEL COHEN

18. Mother's Nama *(First, Middle, Meiden Surneme)*: SADIE SILVERSTEIN

19a. Informant's Neme/Relationship *(Type, Print)*: MRS.MILDRED COHEN/WIFE

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 3203 PARKINGTON AVE. BALTIMORE,MD. 21215

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from Stata 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, crematory or othar placa)*: SHAAREI TFILOH CONG.

Date: 3/18/01

20c. Location - City or Town, Stata: WOODLAWN,MD.

21. Signature of Funeral Service Licensee: Sol Levinson

22. Nama and Address of Facility: SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE,MD. 21208

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failura. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. encelphalopathy

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Renal insufficiency

Due to (or as a consequenca of):

c. Hepatic insufficiency

Due to (or as e consequence of):

d. ~~elbow fracture~~

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the causa of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes ~~2 [X] No~~

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury: M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier *(Check only one)*: 1 [X] **Certifying Phyaician:** To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, In my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: PALLAVI SHAH, DO

29c. License number: RES 0000

29d. Date signed *(Month, Day, Year)*: MARCH 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PALLAVI SHAH, D.O. SINAI HOSPITAL OF BALTIMORE

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 2 8 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Patient known as = Cohen, Isadore

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

ADMEND ITEM: #4a PER PHY. G794 4-2-01 VR

1- For State Registrar AMND#5 PR. INFMT. G794 4-5-01 JAB

# State of Maryland - Department of Health and Mental Hygiene
# Certificate of Death

Reg. No. 2001 09483

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Wilbur Davis

2. Date of Death Month Day Year: March 27, 2001

3. Time of Death: 7:30 AM M

4a. Facility Name (If not institution, give street and number): MANOR CARE- ROSSVILLE NURSING CENTER ~~Franklin Woods Nursing Center~~

4b. City, Town, or Location of Death: Rossville

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: ~~243~~ 243 32 0252

8. Sex: 1 ☐ M 2 ☐ F — X

7. Age (In yrs. last birthday): 76 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 28, 1924

9. Birthplace (State or Foreign Country): Louisiana

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Essex

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 814 Myrth Avenue

10f. Zip Code: 21221

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mechanical Maintenance

18b. Kind of Business/Industry: Beth. Steel Corp.

17. Father's Name (First, Middle, Last): (UNKNOWN)

18. Mother's Name (First, Middle, Maiden Surname): (UNKNOWN)

19a. Informant's Name/Relationship (Type, Print): Jane Davis (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 814 Myrth Avenue Essex, Maryland 21221

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Greenmount Crematory

Date: 3/30/2001

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: M00694

22. Name and Address of Facility: Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finat disease or condition resulting in death): a. Cardiomyopathy — 1 Month

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as e consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnency: 1 ☐ Live birth 2 ☐ Fetel death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of deeth 5 ☐ Othar (specify) 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probebly 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Oulpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Netural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2 ☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and manner state

29b. Signature and title of certifier

29c. License number: D45475

29d. Date signed (Month, Day, Yaar): 3/28/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Mohammed Rahnama MD 8100 Harford Road Baltimore, Maryland 21234

**State Registrar**

31. Date filed (Month, Day, Year): MAR 2 8 2001

32. Registrar's Signature: Bernard J Sparks

DHMH 17 Rev 1/2001

ORIGINAL

---

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 09484

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Elbert Ralph Dawson
2. Date of Death (Month, Day, Year): March 23, 2001
3. Time of Death: 6:10 PM
4a. Facility Name (If not institution, give street and number): 1611 Frenchs Avenue
4b. City, Town, or Location of Death: Essex
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 217-03-6908
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 25, 1918
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Essex
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1611 Frenchs Avenue
10f. Zip Code: 21221
10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: 1944 1946
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Manager
18b. Kind of Business/Industry: Paper

17. Father's Name (First, Middle, Last): James Elmer Dawson
18. Mother's Name (First, Middle, Maiden Surname): Velma Reed

19a. Informant's Name/Relationship (Type, Print): Viola Jessie Dawson (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1611 Frenchs Avenue Essex, Maryland 21221

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Oaklawn Cemetery | Date: 3/27 2001
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Michael C. Bruzdzinski M00938
22. Name and Address of Facility: Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. congestive heart failure
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetel death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
emphysema

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rodney Brooks MD
29c. License number: 043636
29d. Date signed (Month, Day, Year): March 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 3301 Belair Road Baltimore, Maryland 21213

**State Registrar**

31. Date filed (Month, Day, Year): MAR 28 2001
32. Registrar's Signature: Peter D Spaeth

DHMH 17 Rev 1/2001

ORIGINAL

---

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

93-07

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09485

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|
| SYLVIA | DIER | March 26, 2001 | 3:18 a.m. |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Sinai Hospital of Baltimore | Baltimore | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 056-07-7508 | 1 ☐ M 2 XX F | 86 Yrs. | | | DEC. 30, 1914 | N.Y. |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | BALTIMORE | LUTHERVILLE | 1 ☐ Yes XX No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 209 MORRIS AVENUE | 21093 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married XX Widowed 4 ☐ Divorced | 1 ☐ Yes XX No If Yes, Give Year or Dates: | 1 ☐ Yes XX No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 1 | SALES | FOOD |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| MAX HELLERMAN | BERTHA (UNKNOWN) |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| JEFFREY DIER / SON | 209 MORRIS AVENUE - LUTHERVILLE, MD 21093 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other piece) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | BETH SHALOM CEMETERY | 3/27/01 | CAPITOL HEIGHTS, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] | SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Pneumonia | |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. | |
| | Due to (or es a consequence of): | |
| | c. | |
| | Due to (or es a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

**23b. Did tobacco use contributa to the cause of death?** 1 ☐ Yes 2 ☐ No 3 ☐ Probably XX Unknown

| 24a. Wes an autopsy performed? | 24b. Were autopsy findings available prior to completion of ceuse of death? |
|---|---|
| 1 ☐ Yes XX No | 1 ☐ Yes 2 ☐ No |

| 25. Was casa referred to medicel examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 ☐ Yes 2 XX No | Hospital: XX 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Dey Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| XX 1 Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ Yes 2 ☐ No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one) XX 1 **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ P. Ogbogu MD | P14279 | March 26, 2001 |

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)
P. Ogbogu, Sinai Hospital, 2401 W. Belvedere, Baltimore, MD

**State Registrar**

| 31. Date filed (Month, Dey, Year) | 32. Registrar's Signature |
|---|---|
| MAR 28 2001 | [signature] |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Dier, Sylvia

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 09486

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Helen M. Edwards | Mar. 24, 2001 | 6:20 AM M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 2020 Breitwert Avenue | Morrell Park | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-24-1967 | 1☐ M 2☒ F | 91 Yrs. | | | Dec. 19, 1909 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | n/a | Morrell Park | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2020 Breitwert Avenue | 21230 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8 | 0 | Homemaker | Ownhome |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| David C. Henneberry | Ada E. Loney |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Joseph D. Edwards / Son | 101 Litton Dale Lane, Pasadena, Maryland 21122 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Lorraine Park Cemetery | 3/27/01 | Baltimore, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ | Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Cerebrovascular Accident | 10 days |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): Arteriosclerotic Cardiovascular Disease | 15 years |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown | 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Harjit Singh M.D. | D0014160 | 03/26/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Harjit Singh, M.D. 5410-A Ritchie Highway Baltimore, Md. 21225

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 28 2001 | ▶ Geneva G. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To be Completed by Funeral Director**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 72 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Amended Item#7 perABG794 4/4/01 EW

Reg. No. 2001 09487

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| PAUL | | FUNK | MARCH | 10 | 2001 | 8:40 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| GOOD SAMARITAN HOSPITAL | BALTIMORE | BALTIMORE |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year Months | Days | If Under 24 Hrs. Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 215-20-9973 | 1 [X] M 2 [ ] F | ~~77~~ 76 Yrs. | | | | | Nov 11, 1924 | unk |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | | Baltimore | 1 [X] Yes 2 [ ] No |

| 10a. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2108 Pelham Avenue | 21218 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| unk<br>1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | unk<br>1 [ ] Yes 2 [ ] No<br>If Yes, Give Year or Dates: | 1 [ ] Yes 2 [X] No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | unk | unk |
| unk | unk unk | | |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| | unk |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Good Samaritan Hospital | 5601 Loch Raven Blvd Baltimore, MD 21239 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) in state | | | |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Joseph B. Van Sant | State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. PNEUMONIA | 10 days |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE | years |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23b. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown | 1 [ ] Yes 2 [X] No | 1 [ ] Yes 2 [X] No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 [ ] Yes 2 [X] No | Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] Yes 2 [ ] No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| N Damaj MD | 011902 | MARCH 23, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Nouhad Damaj - Good Samaritan Hospital 5601 Loch Raven Blvd.

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 28 2001 | Geneva G Sparks |

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

DHMH 16 Rev 6/95

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 09488

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| EDWARD LEE | FLORANCE | SR | 03 / 25 / 2001 | 1:55 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Glade Valley Nursing Center | Walkersville | Frederick |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 577-26-5120 | 1 [X] M 2 [ ] F | 85 Yrs. | | | 10-15-1915 | Virginia |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Frederick | Frederick | 1 [X] Yes 2 [ ] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1421 Taney Ave #624 | 21702 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: | 1 [ ] Yes 2 [X] No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8th | | Contractor | Homebuilding |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| William Logan Florance | Dora Frances Lunsford |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Sister Frances Rebecca Meese | 413 N. 3rd st Oakland, MD 21550 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify) | | | |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Joseph B. Van Sant | State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

| | | |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Pneumonia | 1 day |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1 [ ] Yes 2 [ ] No 9 [ ] Unknown | 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown | |

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia
Diabetes Mellitus
Gangrene of foot

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 [ ] Yes 2 [X] No | 1 [ ] Yes 2 [ ] No |

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) | |
|---|---|---|
| 1 [ ] Yes 2 [X] No | Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] Yes 2 [ ] No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Allen J. Gilson MD | D 26516 | MARCH 25 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Allen J. Gilson MD 1475 JANEY AVE FRED MD 21702

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 28 2001 | ▶ Brenda D. Sparks |

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print In Black indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 09489

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: GLADYS FLEMING
2. Date of Death Month MARCH Day 19, Year 2001: 
3. Time of Death: 9:00 PM
4a. Facility Name *(If not institution, give street and number)*: HAMMONDS LANE CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

**Funeral Director**

5. Social Security Number: 220-24-7756
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 19, 1907
9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 613 Hammonds Lane
10f. Zip Code: 21225
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): unk | College (1-4or 5+): unk
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: unk
16b. Kind of Business/Industry: unk

17. Father's Neme *(First, Middle, Last)*: unk
18. Mother's Name *(First, Middle, Meiden Surneme)*: unk

19a. Informent's Name/Reletionship *(Type, Print)*: Hammonds Lane Center
19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, State, Zip Code)*: 613 Hammonds Lane Baltimore, MD 21225

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other *(Specify)* in state
20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*:
Date:
20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Joseph B. Van Sant
22. Nama and Addrass of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complicetions thet caused the death. Do not enter the mode of dying, such as cerdiec or respiretory arrest, shock, or heert failure. List only one cause on each line.

Approximate Interval Between Onsat and Death

Immediate Cause (Finel diseese or condition resulting in death)
e. End Stage Dementia — 3 years

Due to (or es a consequence of):
b. Cerebro vascular Accident — 5 years

Sequantiellly list conditions, if sny, leading to immediete ceuse. Enter Underlying Ceuse (Disease or injury thet initiated events resulting in death) Lest

Due to (or es e consequenca of):
c.

Due to (or as e consequence of):
d.

Part fl. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.
Atrial Fibrillation
Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cese referred to medicel examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Mannar of Death: 1☒ Naturel 2☐ Accident 3☐ Sulcida 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury *(Month, Day Year)*:
28b. Time of Injury:
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred:
28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*:
28f. Location *(Street end Number or Rural Route Number, City or Town, State)*:

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and piece, end due to the ceuse(s) and manner ss stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and mannar stated.

29b. Signatura and title of certifier: MD
29c. Licansa number: D53462
29d. Data signad *(Month, Day, Year)*: 3/20/01

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Jude Muneses MD 7845 Oakwood Road Glen Burnie, MD 21061

**State Registrar**

31. Dete filed *(Month, Day, Year)*: MAR 2 8 2001
32. Registrer's Signature: G Sparks

DHMH 16 Rev 6/95

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09490

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Patricia L. Flynn
2. Date of Death: Month MAr Day 25 Year 2001
3. Time of Death: 2117
4a. Facility Name (If not institution, give street and number): Anne Arundel Gen Hosp.
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: AA

**Funeral Director**

5. Social Security Number: 167-40-7668
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 54 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN 13, 1947
9. Birthplace (State or Foreign Country): VA

Usual Residence of Decedent

10a. State: PA
10b. County: Westmoreland
10c. City, Town or Location: Greensburg
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 229 Wren Drive
10f. Zip Code: 15601
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Edward Shunk
18. Mother's Name (First, Middle, Maiden Surname): Emma Lucille Kurtz

19a. Informant's Name/Relationship (Type, Print): William R. Flynn/husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 229 Wren Drive Westmoreland, PA 15601

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. Clair Crematory
Date: 3/29
20c. Location - City or Town, State: Greensburg, PA

21. Signature of Funeral Service Licensee: Daniel Simons
22. Name and Address of Facility: Bacha Funeral Home, Inc. 516 Stanton St Greensburg, PA 15601

**Physician Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Myocardial Infarction — Minutes

Due to (or as a consequence of):
b. Arteriosclerotic Heart Disease — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: William P. Jones Deputy MD
29c. License number: D 06054
29d. Date signed (Month, Day, Year): 3/26/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William P. Jones, MD 695 America 21035

**State Registrar**

31. Date filed (Month, Day, Year): MAR 28 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 09491

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): MALCOLM M. FISHER
2. Date of Death: Month March Day 26 Year 2001
3. Time of Death: 10:30 AM
4a. Facility Name (If not institution, give street and number): St Agnes Healthcare
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 219-10-1157
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 76 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 8-15-1924
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD.
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 509 N. DENNISON ST.
10f. Zip Code: 21229
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): -12-; College (1-4or 5+): -2-
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): WAREHOUSEMAN
16b. Kind of Business/Industry: DEPARTMENT STORE

17. Father's Name (First, Middle, Last): UNKNOWN
18. Mother's Name (First, Middle, Maiden Surname): UNKNOWN

19a. Informant's Name/Relationship (Type, Print): PATRICIA MITCHELL(DAUGHTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 29242 W. KENNEDY ST. EASTON, MARYLAND 21601

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): LOUDON PARK
Date: 3-31-2001
20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: Sarah D. Hibner
22. Name and Address of Facility: PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis — Approximate Interval Between Onset and Death: hours

Due to (or as a consequence of):
b. Pneumonia — hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnent at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Renal failure, heart failure, recent myocardial infarction, coronary artery disease

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
28. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and manner stated.
29b. Signature and title of certifier: D M Hardy
29c. License number: #P14443
29d. Date signed (Month, Day, Year): March 26, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type/Print): Daniel Hardy St Agnes Hospital 900 Caton Ave Balto Md 21229

**State Registrar**

31. Date filed (Month, Day, Year): MAR 28 2001
32. Registrar's Signature: Barbara D. Sparks

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Division of Vital Records, P.O. Box 68760,**

**To Be Completed by Funeral Director**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

NAME Fisher, Malcolm

DHMH 17 Rev 1/2001

ORIGINAL

Marie Graham

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 09492

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: MARIE GRAHAM

2. Date of Death — Month: MAR Day: 24 Year: 2001

3. Time of Death: 505 PM

4a. Facility Name *(If not institution, give street and number)*: BON SECOURS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

**Funeral Director**

5. Social Security Number: 220-20-0805

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 79 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: 10/30/1921

9. Birthplace *(State or Foreign Country)*: South Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 701 North Arlington Avenue

10f. Zip Code: 21217

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): 3 College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife

16b. Kind of Business/Industry: Homemaker

17. Father's Name *(First, Middle, Last)*: David Forman

18. Mother's Name *(First, Middle, Maiden Surname)*: Bessie Charles

19a. Informant's Name/Relationship *(Type, Print)*: Maxie Graham / Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1950 W. Pratt Street, Baltimore, Maryland 21223

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Arbutus Memorial Pk. Ceme

Date: 03/30/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: Derrick C. Jones Funeral Home 4611 Park Heights Avenue, Baltimore, Maryland 21215

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiogenic Shock — 2 days

Due to (or as a consequence of):

b. Acute MI

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. ASCVD

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)* — Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*:

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred:

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*:

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*:

29a. Certifier *(Check only one)* 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Richard Young, MD

29c. License number: D26256

29d. Date signed *(Month, Day, Year)*: 3/27/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RICHARD YOUNG, MD 700 Washington Blvd Baltimore MD 21230

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAR 2 8 2001

32. Registrar's Signature: Barbara G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

RKD

01-1279-510

CHARLESTTA GANTT

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED# 26 per ME G793 031501 SS 793 032801 SS Amend item 1, 23a, 27, 28a-f per ME G793 011501 SS AMENDED#20b per fh G793 011501 SS

# Certificate of Death

Reg. No. 2001 09493

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Charlesetta Gant — Charsletta Stephinia Yetla Gantt

2. Date of Death: Month MARCH Day 7 Year 2001

3. Time of Death: 8:45P. M

4a. Facility Name (If not institution, give street and number): 605 DUMBARTON AVE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 212-86-5175

6. Sex: 1☐ M 2☑ F

7. Age (In yrs. last birthday): 32 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 6, 1968

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☑ Yes 2☐ No

10e. Street and Number: 612 Cator Ave.

10f. Zip Code: 21218

10g. Citizen of What Country? USA

11. Marital Status: 1☑ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9th; College (1-4or 5+):

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unk.

18b. Kind of Business/Industry: unk.

17. Father's Name (First, Middle, Last): Charles Gantt

18. Mother's Name (First, Middle, Maiden Surname): Ethel Clanton

19a. Informant's Name/Relationship (Type, Print): Robin Gantt - Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 702 Cator Ave. Balto., MD. 21218

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion Cemetery — Date: 3/13/01 — 3-12-01

20c. Location - City or Town, State: Lansdowne, MD

21. Signature of Funeral Service Licensee: Gary D. Marsh

22. Name and Address of Facility: Gary Fredrickson Marsh Funeral Home P.A. 270 Fredrickson Mill Balto., MD 21229

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. NARCOTIC AND ALCOHOL INTOXICATION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

Due to (or as a consequence of): b.

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☑ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☑ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) at scene

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☑ Could not be determined

28a. Date of Injury (Month, Day Year): found 3-7-01

28b. Time of Injury: found 8:40 PM

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): found at home

28f. Location (Street and Number or Rural Route Number, City or Town, State): 605 Dunbarton Ave., Balto., MD

**Medical Certification; To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J Pestaner, M.D

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): MARCH 8, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): MAR 12 2001

32. Registrar's Signature: G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Amended Item#9 perFHG793 3/29/2001 EW

# Certificate of Death

Reg. No. 2001 09494

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| William L. GREENE | March 21st 2001 | 2:45 pm |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Manor Care – Largo | Largo | Prince Georges |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 249-30-5519 | 1☐M 2☒F | 75 Yrs. | | | July 1st 1925 | Charleston S.C. |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| DC | | Washington | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1217 Valley Ave SE Apt# 103 | 20020 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 4 | Real Estate Broker | Private |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Edward Greene | Eva Swinton |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Janice L. Greene/ Daughter | 33 West 131 Street, New York, NY 10037 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Metropolitan Crematory | 3/27/01 | Alexandria, VA |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Timothy Adkins | Robert G.Mason Funeral Home 1661 Good Hope Rd., SE,Washington, DC 20020 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. CARCINOMA LUNG WITH METASTASES | 1 YEAR |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23b. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☒Yes 2☐No 3☐Probably 4☐Unknown | 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Paul A. DeVore MD | D01852 | MARCH 27 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Paul A. DeVore MD 4203 Queensbury Rd Hyattsville MD 20781

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 28 2001 | ▶ Geneva D. Sparks |

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09495

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): HATTIE MAY GILL

2. Date of Death: Month MARCH Day 26 Year 2001

3. Time of Death: 07:10 PM

4a. Facility Name (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death: TOWSON

4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 217-03-4858

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 22, 1917

9. Birthplace (State or Foreign Country): VA

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Towson

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 726 Camberley Cr. Apt. A5

10f. Zip Code: 21204

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Home maker

16b. Kind of Business/Industry: Own home

17. Father's Name (First, Middle, Last): Earl Newton

18. Mother's Name (First, Middle, Maiden Surname): Sally Jones

19a. Informant's Name/Relationship (Type, Print): Mrs. Nancy McDermott/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 733 Camberley Cr. Apt. A3 Towson, MD 21204

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens of Faith

Date: 3/30/01

20c. Location - City or Town, State: Overlea, MD

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD 21204

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart failura. List only one ceuse on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disaase or condition resulting in death) a. | CEREBRAL VASCULAR ACCIDENT | 8 DAYS |
| Due to (or as a consequence of): b. | PNEUMONIA | 17 DAYS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c. | ATRIAL FIBRILLATION | 17 DAYS |
| Due to (or as a consequence of): d. | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Fred Chan M.D.

29c. License number: D53430

29d. Date signed (Month, Day, Year): MARCH 26, 2001

30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print): FRED CHAN MD. 6701 NORTH CHARLES STREET BALTIMORE MARYLAND 21204

**State Registrar**

31. Date filed (Month, Day, Year): MAR 28 2001

32. Registrar's Signature: Geraldine D Sparks

ORIGINAL

DHMH 16 Rev 6/95

---

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

HATTIE GILL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No: 2001 09496

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Dorothy N. Hammond
2. Date of Death (Month, Day, Year): March 26 2001
3. Time of Death: 7:30 a.m.
4a. Facility Name (If not institution, give street and number): 5313 Sweetwater Drive
4b. City, Town, or Location of Death: West River
4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 261-62-4726
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 97 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 1, 1903
9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: West River
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5313 Sweetwater Drive
10f. Zip Code: 20778
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Edwin J. Nelson
18. Mother's Name (First, Middle, Maiden Surname): Bertha Macomber

19a. Informant's Name/Relationship (Type, Print): Harry B. Cannon (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5313 Sweetwater Drive, West River, MD 20778

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory
Date: 03/28 2001
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Aortic Dissection — Approximate Interval Between Onset and Death: 11 days

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D38563
29d. Date signed (Month, Day, Year): March 26, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Wayne Bierbaum 134 Owensville Rd West River MD

**State Registrar**

31. Date filed (Month, Day, Year): MAR 2 8 2001
32. Registrar's Signature: [signature] D Sparks

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 09497

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Bertha Hyman

2. Date of Death (Month, Day, Year): March 27, 2001

3. Time of Death: 5:35 P M

4a. Facility Name (If not institution, give street and number): Sunrise Assisted Living

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard

**Funeral Director**

5. Social Security Number: 122-12-6547

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): OCT 16, 1912

9. Birthplace (State or Foreign Country): NY

Usual Residence of Decedent

10a. State: NY

10b. County: Fulton

10c. City, Town or Location: Sacandaga

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 122 Roosevelt Terrace

10f. Zip Code: 12134

10g. Citizen of What Country? USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates: X

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify: X

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Home Maker

18b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Louis Berkman

18. Mother's Name (First, Middle, Maiden Surname): Bessie Levine

19a. Informant's Name/Relationship (Type, Print): Lawrence R. Hyman/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3681 Folly Quarter Rd Ellicott City, MD 21042

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other piece): Temple of Israel

Date: 4/01/01

20c. Location - City or Town, State: Cranesville, NY

21. Signature of Funeral Service Licensee: Daniel Simons

22. Name and Address of Facility: Betz-Rossi & Bellinger Family Funeral Home 171 Guy Park Ave, Amsterdam, NY 12010

**Physician /Medical Examiner**

23a. Part1. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Malignant Arrhythmia — Seconds

Due to (or as a consequence of): b. Valvular Heart Disease — Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) Assisted Living

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D22856

29d. Date signed (Month, Day, Year): March 27, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jeremy Levine, 500 11055 Lottsford Rd Columbia MD 21044

**State Registrar**

31. Date filed (Month, Day, Year): MAR 28 2001

32. Registrar's Signature: G Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 09498

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| Lillian Marie Hausner | | | March 24, 2001 | 10:25 pm |
| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death | | |
| Johns Hopkins Bayview Medical Center | Baltimore City | | | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-09-1661 | 1☐M 2☒F | 87 Yrs. | | | Dec. 19, 1913 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Dundalk | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 7029 Sollers Point Road | 21222 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 6 | | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Martin Janiszewski | Maryanna Czykowska |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Ronald Joseph Hausner (son) | 1686 Fallsway Drive, Crofton, Maryland 21114 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Gardens of Faith Cem. | March 27, 2001 | Baltimore, Maryland |

| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility |
|---|---|---|
| Brian W. Bruzdzinski | M01267 | Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Myocardial infarction | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. Coronary art Dis history | |
| | Due to (or as a consequence of): c. Breast Cancer dtg | |
| | Due to (or as a consequence of): d. Myelodysplasia | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☒No 3☐Probably 4☐Unknown | 1☐Yes 2☒No | 1☐Yes 2☐No |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Sheila Alongi MD | D0046595 | 3/26/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SHEILA ALONGI 1911 Maryland Ave Suite 102 Balt, md 21237

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAR 28 2001 | S Sparks |

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 09499

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: DAVID CURTIS HUME
2. Date of Death Month Day Year: MARCH 26, 2001
3. Time of Death: 6:15 P.M.
4a. Facility Name *(If not institution, give street and number)*: VAMHCS, FORT HOWARD DIVISION
4b. City, Town, or Location of Death: FORT HOWARD
4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 216-52-4442
6. Sex: 1☐ M 2☐ F — X
7. Age *(In yrs. last birthday)*: 51 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 30, 1949
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: ROSEDALE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7934 BERK LANE
10f. Zip Code: 21237
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Year or Dates: VIETNAM
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Ricen, atc.): 1☐ Yes 2☒ No *Specify:*
14. Race - Amarican Indian, Black, Whita, atc. *Specify:* WHITE

15. Decedent's Education *(Specify only highast grada complatad)*: Elementary/Secondary (0-12): 9 — Collega (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratired)*: Gibralter
16b. Kind of Businass/Industry: Contstruction

17. Fathar's Nama *(First, Middla, Last)*: GILBERT C. HUME
18. Mother's Nama *(First, Middla, Maiden Sumame)*: AMELIA DOLAN

19a. Informant's Name/Ralationship *(Type, Print)*: AMELIA HUME/Mother
19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 7934 BERK LANE BALTIMORE MD 21237

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Othar *(Specify)*
20b. Place of Disposition *(Name of cematary, cramatory or othar place)*: OAKLAWN CEMETERY — Data: 3-29-01
20c. Location - City or Town, Stata: BALTIMORE MD

21. Signature of Funaral Sarvice Licensee: [signature]
22. Name and Addrass of Facility: CVACH/ROSEDALE FUNERAL HOME 1211CHESACO AVENUE BALTIMORE MD 21237

**Physician /Medical Examiner**

23a. Part1. Entar tha disaase, or complications that ceused the death. Do not enter tha mode of dying, such as cerdiac or raspiratory arrast, shock, or haart failura. List only ona cause on each line.

Approximate Interval Batween Onsat and Death

Immediata Cause (Finat diseasa or condition resulting in death)
a. HUMAN IMMUNODEFICIENCY VIRUS INFECTION — 8 YEARS

Due to (or as a consequence of):
b. HEPATITIS C — 8 YEARS

Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Causa (Disease or Injury that initiated events rasulting in death) Last
Dua to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Were autopsy findings available prior to completion of causa of death? 1☐ Yes 2☐ No

25. Was casa rafarred to medical examiner? 1☐ Yas 2☒ No
26. Placa of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Othar: 4☐ Nursing Homa 5☐ Residence 6☐ Othar *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarmined
28a. Data of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Dascribe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stata)*

29a. Certifiar *(Check only one)*: 1☒ **Certifying Physician**: To tha best of my knowladga, daath occurred at tha tima, data and place, and due to tha causa(s) and mannar as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated.

29b. Signatura and titla of certifiar: John S. Lah M.D.
29c. License number: 34359 (OH10)
29d. Data signed *(Month, Day, Year)*: 3 29 2001

30. Nama and address of person who completed cause of daath (Item 23a) (Type, Print): DR. JOHN LAH, MD--9600 NORTH POINT RD., FORT HOWARD, MARYLAND 21052

**State Registrar**

31. Data filed *(Month, Day, Year)*: MAR 28 2001
32. Registrar's Signatura: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

---

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

DAVID C. HUME

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

ADMEND ITEM: #8 PER F.H. G794 4-6-01 WR

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item#7 perFHG794 4/6/2001 EW

# Certificate of Death

Reg. No. 2001 09500

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Amin Juba

2. Date of Death: Month March Day 26 Year 2001

3. Time of Death: 10:30 PM

4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 220-72-4846

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 35 ~~37~~ Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): SEPT. 23, 1965 ~~1963~~

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE CITY

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 33 ASHLAR HILL COURT

10f. Zip Code: 21234

10g. Citizen of What Country? USA.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 2 YRS. College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DORM SUPERVISOR

16b. Kind of Business/Industry: JOB CORP.

17. Father's Name (First, Middle, Last): TYREE HIGGINS

18. Mother's Name (First, Middle, Maiden Surname): LOUISE WALKER

19a. Informant's Name/Relationship (Type, Print): LOUISE HIGGINS (MOTHER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 33 ASHLAR HILL CT., BALTO, MD. 21234

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MT. ZION CEMETERY Date: 03-27-01

20c. Location - City or Town, State: LANSDOWNE, MARYLAND

21. Signature of Funeral Service Licensee: Ruth A. Wells

22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTO. MD. 21217

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis — Approximate Interval Between Onset and Death: 1 week

Due to (or as a consequence of):

b. Pneumonia — 2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Anaplastic large cell lymphoma of the liver — 1 month

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Renal Failure

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of causa of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rebecca Gottesman MD, Resident Physician

29c. License number: 21015

29d. Date signed (Month, Day, Year): March 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Rebecca Gottesman, 4940 Eastern Avenue, Baltimore, Maryland 21224

**State Registrar**

31. Date filed (Month, Day, Year): MAR 28 2001

32. Registrar's Signature: Geneva D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.